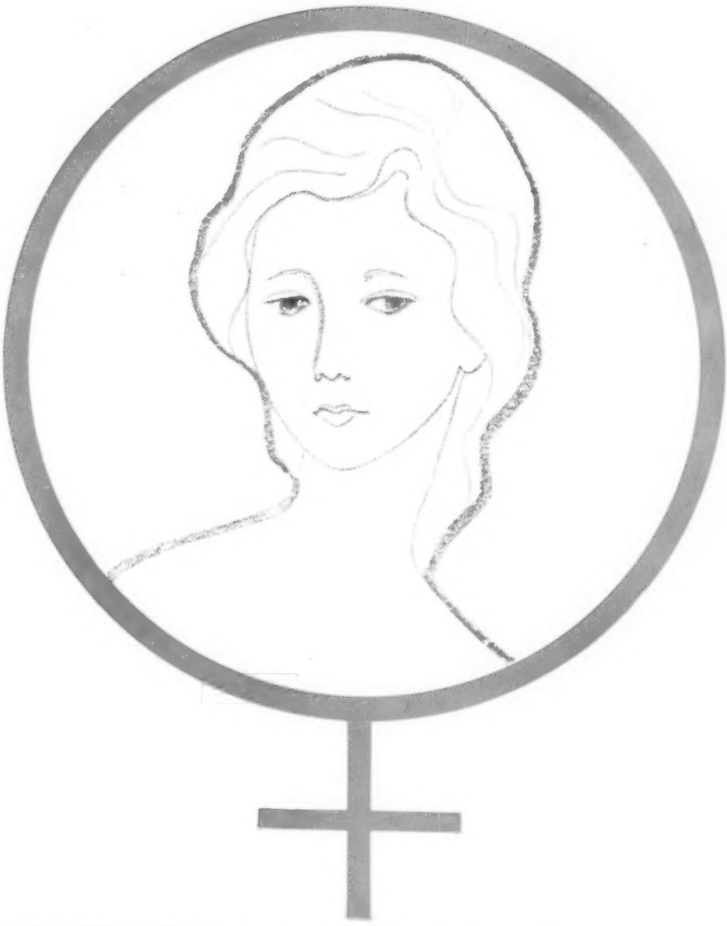
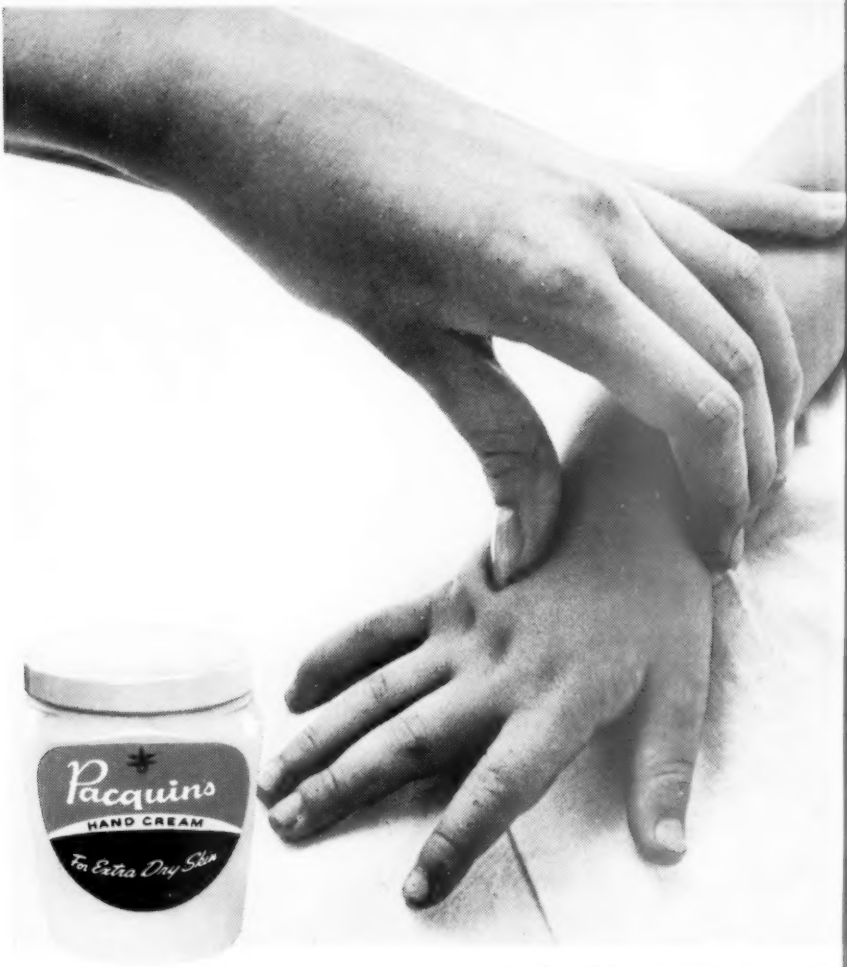
RN

MARCH 1960



POSTPARTUM MENTAL ILLNESS



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- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

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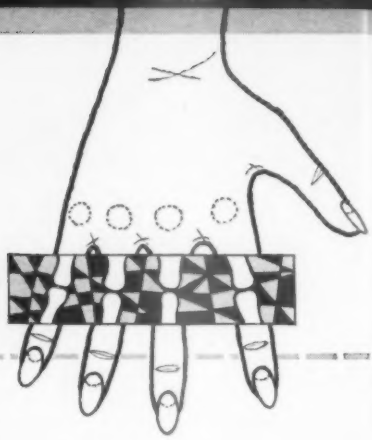

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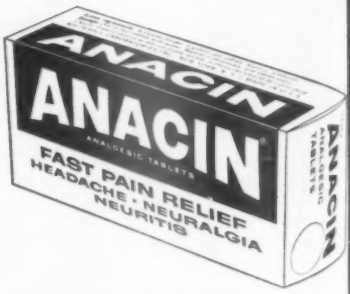

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RN letters

UPSETTING COMPARISON

DEAR EDITOR: It upsets me when I hear, or read, that nurses get as much pay as some teachers. While the *yearly* salary of both may be the same in some situations, consider these facts:

Teachers work only nine months a year; nurses, twelve. Teachers never work on week-ends or holidays. Teachers get a week or more of vacation at Christmas and again in the spring.

On a pay-per-working-day basis, nursing is still the lowest paid profession.

Beth Kole, R.N.
Carpentersville, Ill.

A PART-TIMER REPORTS

DEAR EDITOR: I wish those who criticize the part-timer so freely would remember that she has her problems too.

When I went back to part-time work after a seven-year absence, my ego took quite a shellacking. I was sure I hadn't changed—but I soon discovered I was outdated, and slow.

Part-timing isn't easy. You don't know the patients . . . Someone is always rearranging the closets, so you have to look in six places to find what you need . . . The doctors on call are changed every few months (oh, sure, there's a schedule—if you can find it) . . . Some of the younger nurses look at you as if you were too ancient to live . . .

Most patients seem to prefer the part-timers because we give them old-fashioned care . . . Many times I saw younger R.N.s sitting at the nurses' station, coffee-klatching instead of chatting with some lonely or worried patient.

Despite these things, I love nursing. I still go in to help out—sometimes on an hour's notice.

Madeline K. Ogden, R.N.
Mineola, N.Y.

'SPLINT THEM . . .'

DEAR EDITOR: Your recent article "Splint Them Where They Lie" is excellent. My wife (an R.N.) and I plan to use it "as is" in teaching first aid to local Red Cross classes.

Edward O. Lukasek, M.D.
Sparta, Wis.

JOB-CHANGING

DEAR EDITOR: I certainly agree with the *RN* correspondent who says

that doing routine work in the same environment year after year can stifle professional growth.

For a time I broke up *my* routine by, among other things, attending workshops and district meetings. Then I switched to private duty. Now I find that working in different hospitals engenders greater insight and renewed interest.

Marie Wilson Garvue, R.N.
Minneapolis, Minn.

CLEANING TIP

DEAR EDITOR: Re your recent item about stains on uniforms: Rubbing alcohol will quickly remove ink stains from a nylon uniform without leaving telltale rings.

Marion A. Burkwall, R.N.
Columbus, Ohio

WHY NOT HAWAII?

DEAR EDITOR: I enjoyed the article about nursing in Alaska. Why don't you carry a similar piece about our beautiful 50th state?

R.N., Hilo, Hawaii

For a time, RN *had such an article under preparation. Hawaiian nurses' organizations and many former mainland nurses now in the islands courteously supplied information.*

But it soon became clear that we would end up with not much more than a travelogue about the Hawaiian Islands. For of all the states, Hawaii alone has no nurse shortage. Opportunities for mainland nurses are so limited there that we would only have tantalized the reader! Consider these facts, for instance:

¶ A mainland nurse can't be appointed to a position in Hawaii unless there's no qualified resident available.

¶ If she does get an appointment, it's for a year at a time. She must live in Hawaii for three years before her appointment becomes permanent.

¶ Even if she manages to snag one of the few Civil Service jobs that are sometimes open on the outer islands, she must pay her own transportation to Hawaii.

Of course, it's to the credit of our progressive 50th state that it has successfully developed its own nursing force. (Three nursing schools on Oahu graduate about 100 nurses yearly.) But this fact doesn't spell opportunity for the mainland nurse—or an article for RN *readers.*—ED.

'BOTTOM OF THE BARREL'

DEAR EDITOR: We can't join a union, say nurses, for *we* are professional people.

Indeed we are. But does anyone know it except us? Take a look at this example:

Last summer when I substituted for an industrial nurse, the em-

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letters

ployer said the pay would be $2.34 an hour, or $18.72 a day. "Not enough," I told him. "Our county nurses' association says a relief nurse is entitled to the private-duty rate of $20 a day."

The employer haw-hawed. "What authority," he asked, "does your association have over this company?"

See what I mean?

It's high time we nurses started raising ourselves off the bottom of the proverbial barrel. If we don't want a union, then let's strengthen the organizations we already have. A professional group *can* be strong. Look at the A.M.A.

R. K. Kinne, R.N.
Burlingame, Calif.

WORK-SAVER

DEAR EDITOR: On OB/Gyn. wards, where hourly enemas are common, the disposable enema set that requires no preparation is a real work-saver. I'm surprised some hospitals don't seem to recognize this.

Mary M. Sneyers, R.N.
Newark, N. J.

YARDSTICKS OF COMPETENCE

DEAR EDITOR: I'm all for higher education in nursing. I encourage recent three-year graduates to continue their studies. But degree status shouldn't be our only yardstick for measuring an R.N.'s

Continued on page 99

Which stocking gives you the support you need?

The *Burlington Support Stocking*, of course! The one on her other leg is a white walking sheer. Yet they're *both* so sheer you can't tell which is which.

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P.S. The model in the photograph has the Burlington Support Stocking on her right leg.

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RN news

Pediatricians Praise School Nurses

The school nurse is so important to a school's health program, says the American Academy of Pediatrics, that she's usually "the motivating and coordinating force" on the school health council.

In a report on school health policies, the academy also praises the school nurse for her work in (1) detecting the need for physical exams, (2) training teachers for observation and screening, and (3) interpreting the needs of handicapped children.

Post-Op Catheterization Is Overdone, M.D. Says

Catheterization of post-op patients is far too common. Since it may result in bladder infection, even when carried out carefully, it's up to doctors to halt its overuse.

So says an Indianapolis urologist, Dr. Myron H. Nourse, in a report to the American Medical Association. His prescription:

¶ Don't issue routine orders, thus allowing the procedure to be done at the discretion of the nursing service.

¶ See to it that when catheterization is necessary, nurses rather than aides or orderlies do it.

¶ Improve both the medical and the nursing supervision of the patient.

¶ Spend more time, before and after surgery, instructing patients in how to stimulate spontaneous voiding. (When such instruction was given recently to 2,000 patients, says Dr. Nourse, the percentage of those who had to be catheterized dropped from 18.3 to 1.7.)

O_2 Therapy for Preemies Still Uncontrolled

Are hospitals adequately controlling their O_2 therapy for premature babies now that high concentrations of oxygen are known to cause retrolental fibroplasia?

If the practices of Georgia hospitals are a valid measure, the answer is "No." For there a recent state-wide survey indicates that:

¶ About 72 per cent of the hospitals don't require doctors' written orders, don't use a device for controlling O_2 flow into the incubator, and don't measure the concentration with an oximeter.

¶ About 20.5 per cent of the

hospitals provide some of these controls but not all.

¶ Only about 7.5 per cent meet all three requirements.

The survey was a joint project of the Medical Association of Georgia and the state's public health department.

N.L.N. Charters F.N.C.s

The National League for Nursing, sponsor of some 3,000 Future Nurses' Clubs, is now granting a national charter to each club that can qualify.

To be eligible a club must be organized in a high school; have eight or more members; be open to all interested students (within the policies of the school); have a recognized local sponsor; devote much of its program to exploring careers in nursing; submit reports on request.

Hospitals Favor Degrees For Top Nurses

Relatively few hospital nurses are now required to have college degrees. But many administrators would like to have a much larger percentage of college-trained R.N.s on their staffs.

This fact shows up in a recent national survey sponsored jointly by the Public Health Service and the American Hospital Association. The survey is said to be the first in which hospital administrators have been asked about the kind of training they want their nurses to have.

The following tables summarize replies of administrators in a random sample of 942 hospitals:

HOSPITALS WITH SCHOOLS OF NURSING

	Present Per Cent With Degrees	Per Cent Desired By Hospital
Supervisors	21%	93%
Head nurses	6	65
Staff nurses	2	8

HOSPITALS WITHOUT SCHOOLS

	Present Per Cent With Degrees	Per Cent Desired By Hospital
Supervisors	13%	56%
Head nurses	5	33
Staff nurses	4	8

Here's How Taft-Hartley Affects Your S.N.A.

Attorneys for organized nursing have recently clarified certain sections of the Taft-Hartley Act that apply to nurse-employes. Their major points:

1. A nurses' association cannot be considered a "labor union" within the usual meaning of the term. But for purposes of the Taft-Hartley Act, a nurses' association may be regarded as a "labor organization."

2. The association may—like a labor union—legally act as the collective bargaining agent for an employed group *if the group properly*

designates the association as its agent.

3. An employed group must designate its agent in an election ordered by the National Labor Relations Board. So, if an election is ordered for a group that includes nurses, the name of the state nurses' association *must be on the ballot.* Otherwise, nurses may have no choice except to vote for a union or for no representation at all.

4. To get its name on a ballot, a state association must comply with the same N.L.R.B. rules that labor unions observe.

Food Can Affect/Reflect Emotions, Says Report

The food you eat can (1) affect your emotions, (2) show how well adjusted you are, and (3) reflect your emotional needs, according to several psychological studies reported on in Today's Health. Here's a summary of the report:

Affecting emotions: A well-cooked, satisfying meal is usually a great morale-booster, while an unappetizing meal generally has the opposite effect.

A poorly balanced diet may result in a poorly balanced personality. It may even cause a person to develop psychoneurotic traits.

Indicating adjustment: While it's normal for an individual to dislike a few common foods (for instance, buttermilk, brains, clams), the person who strongly dislikes many foods is apt to be high-strung and emotionally unstable. The person who likes most foods is usually well adjusted.

The person who "just isn't hungry" at breakfast is often a chronic worrier who's troubled by vague anxiety. He usually recovers his appetite by midmorning.

The person who refuses to try new and unusual dishes is more likely to become neurotic than the one who enjoys trying "something different." As neuroticism develops, he tends to dislike more and more kinds of food.

Reflecting emotional needs: Because of their differences in emotional make-up, men enjoy eating more than women do. Women dislike more foods—and dislike them more strongly—than men do.

A sudden craving for a particular food often stems from emotions. For example: In times of stress, some people crave milk (subconsciously they associate it with the security they had in infancy). In moments of self-pity, some crave sweets (chocolates especially) to "reward" themselves.

Pregnant women, subject to many emotional changes, may develop a dislike for foods they formerly enjoyed and a craving for foods they never liked before. Some, say nutritionists at the Brit-

Continued on page 26

ish Ministry of Food and Agriculture, actually crave coal. A few give in, now and then, to coal-nibbling!

Rinse Improves Scrubbing Effect, Study Shows

Using aqueous Zephiran as a rinse following the surgical scrub adds greatly to the germ-killing effectiveness of hexachlorophene soap.

This finding highlights a study of O.R. scrubbing techniques made by Dr. Donald M. Frost of Sioux Falls, S.D. The study, published by the South Dakota medical society, also suggests that:

¶ Cleansing the operative site with hexachlorophene soap on the night before surgery and again the next morning, and applying tincture of Zephiran in the O.R. just before surgery reduces the bacteria count substantially.

¶ Less talk during operations helps to combat the spread of bacteria from the mouths of O.R. personnel.

Privileges to Osteopaths Stir Legal Hassle

Staff nurses and physicians didn't like it when the Nightingale Hospital in El Campo, Tex., granted practice privileges to two osteopaths. So they resigned.

What happened?

1. The hospital promptly revoked the osteopaths' privileges.

2. The R.N.s and M.D.s returned.

3. The osteopaths started legal proceedings.

4. A trial court ordered the privileges reinstated.

5. An appeals court reversed the trial court's decision, upholding the hospital's right to exclude osteopaths.

'Calling Cards' Ease Visitor Problem

Ever wish your hospital would try something—*anything*—to cut down on the number of visitors who troop into patients' rooms?

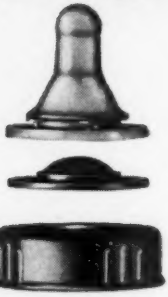
Well, one hospital *is* trying something: Arkansas Baptist, in

Little Rock, provides an attractive "calling card" in waiting rooms.

The folded, note-size "card" has lines on the back of the cover picture for the patient's name and room number, the visitor's name, and the time of his visit. There's plenty of space for a message, too.

Continued on page 106

HERE'S WHY MORE MOTHERS USE *evenflo* NURSERS



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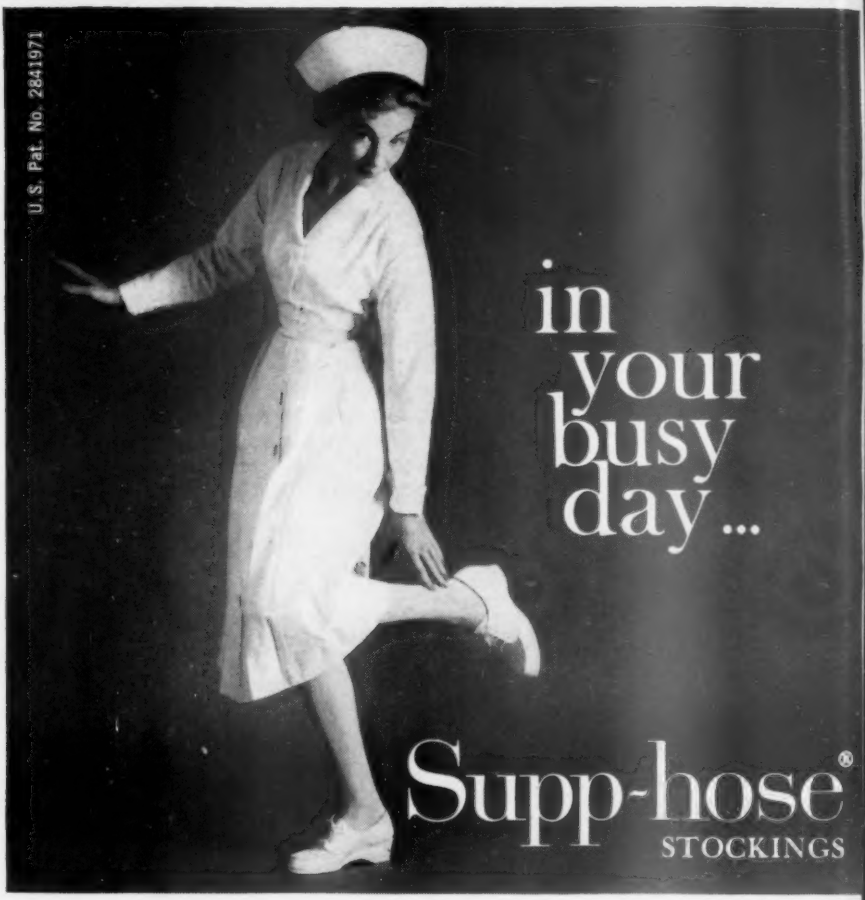

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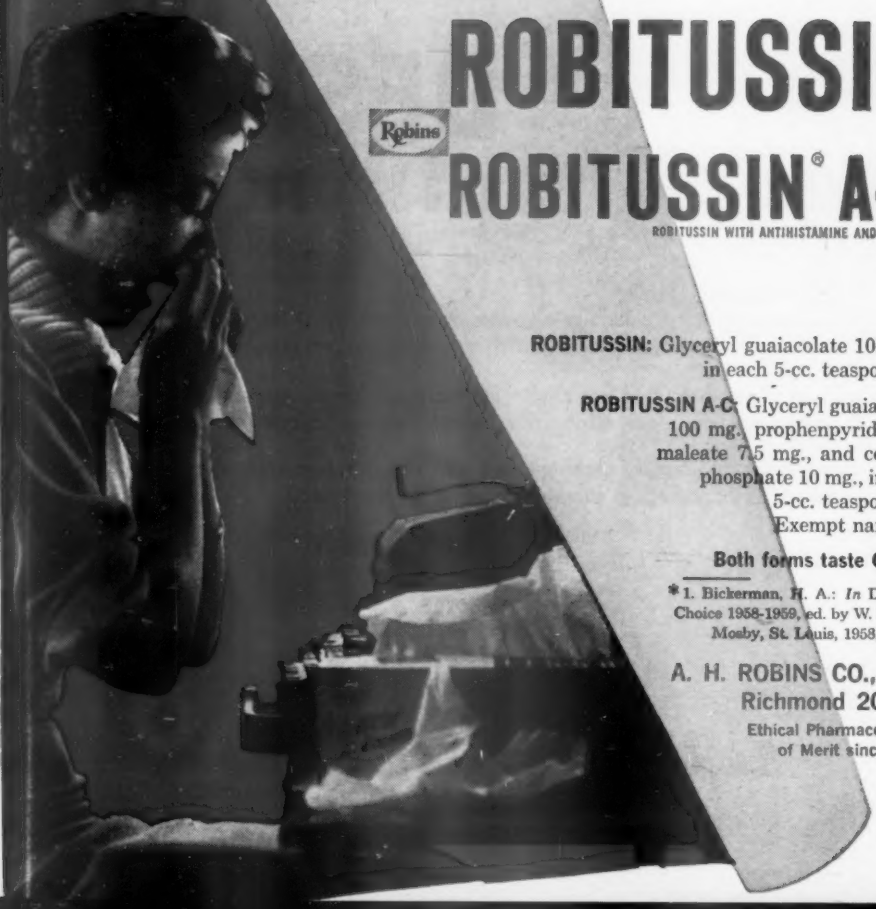

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* 1. Bickerman, H. A.: *In* Drugs of Choice 1958-1959, ed. by W. Modell Mosby, St. Louis, 1958, p. 562.

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FACTS ABOUT PARENTERAL THERAPY: Scores of things nurses want to know on this subject are found in a 48-page book of unusual attractiveness entitled "Parenteral Administration". Valuable for self-instruction or for class room use. Abbott Laboratories **C-2**

PROFESSIONAL UNIFORM FASHIONS The makers of Bob Evans Uniforms have prepared a booklet featuring selections from their new "Designer Series" of professional uniforms which are being shown this year for the first time. In the Designer Series, unique fashion touches are combined with the functional requirements of the profession. Bob Evans Uniform Co., A Div. of Jacobs Bros., Inc. **C-3**

SOAP-FREE CLEANSING BAR: Aveeno Bar offers, for patients who must avoid soap, a combination of colloidal oatmeal in a blend of mild detergents, to provide skin cleansing with soothing skin protection. Literature and a sample are offered. Aveeno Corp. **C-4**

DISPOSABLE FABRIC TISSUE: Made of cotton and rayon, Chix Cleaners afford advantages not found in paper tissues. They can be used wet without shredding as a disposable wash cloth, ointment application or wound cleaner. Samples. Chicopee Mills, Inc. **C-5**

ON YOUR FEET A LOT?: An informative booklet contains all the facts about the development and construction of a sheer all-nylon stocking that gives gentle support to the legs. Of interest to nurses and their patients. Kayser-Roth Hosiery Co., Inc. **C-6**

SOFT FLUFFY DIAPERS: Diaperwite combines modern cleansing agents with hexachlorophene to stop diaper rash caused by irritating diapers. The product disinfects and washes without the need for soap or bleach. A sample is offered. Diaperwite, Inc. **C-7**

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RN

When to Advise a Girl Against Nursing

We need to get the right *girls into our profession, says the author. She tells what qualities to look for, and why*

By Maryjo Williams, R.N.

Not long ago, a good friend of mine came to me for advice about her daughter. "Doris wants to be a nurse," she said. "You know her fairly well. Do you think she's temperamentally suited to nursing?"

My answer was indirect but clear: "Does she willingly help you and others?" I asked.

"Heavens, no!"

"Is she patient?"

My friend ruefully shook her head. "I see your point. Doris has her mind set on nursing, but maybe she would be happier in some other work. I wish you'd have a talk with her."

Doris had a seclusive personality. She was a chronic TV watcher, refused to be hurried for any reason, and resented advice from anyone.

As we talked, it became obvious why she had chosen nursing. She thought the work would be

THIS ARTICLE *won an* RN *Award for its author, a California nurse.*

easy. She dreamed of herself as a future angel of mercy, lovely in white. She saw herself comforting adoring patients and strolling down hospital corridors with a handsome interne on each arm.

Yes, Doris would have looked lovely in white. But even if she had managed to get through nursing school, she would have made a resentful and unhappy nurse. So I didn't spare the de-

The Office Nurse And the Law

BY GEORGE E. HALL, J.D.

The doctor may not tell you so, but you often hold the key to his professional success or failure when you handle matters that could involve him—*and you*—in a lawsuit.

Here are some pointers to help you:

When keeping records: Without accurate *clinical* records, the doctor can become lost, medically and legally. It's impossible for him to recall details of all the treatments he gives, even from week to week. Yet, years later, he may have to produce such details for purposes of further treatments or insurance claims or court testimony or to protect himself against a malpractice suit.

As you keep *appointment* records, you'll do well to note when a patient does *not* show up, as well as when he does. You'll call this to the doctor's attention so he can send a reminder. Such action may nip in the bud any subsequent charge of abandonment.

For your own protection as well as the doctor's, you can suggest that he write to the A.M.A. for a copy of

THE AUTHOR *is an associate in the Law Department of the American Medical Association.*

tails when I told her exactly what nursing is really like. Just a few weeks later I heard that she had buried her nursing dream for good.

At this point I can hear the protests of some of my R.N. friends:

"But *all* young women are idealistic in some degree! They outgrow it!"

"Don't you know we need all

"Medicolegal Forms." This pamphlet tells how to use letters, notes, etc., in legally dangerous situations. (A book entitled "The Office Assistant," by Frederick and Towner, also gives pointers helpful to you both.)

Even the doctor's *business* records could involve him in legal trouble. Suppose, for instance, that he sends a collection agency after a patient who owes him money, according to his records. And suppose the patient has canceled checks to prove he has already paid. The result? The patient can sue for damage to his reputation.

Safeguarding confidential information: You often learn highly personal facts about your patients that only you, the patients, and the doctor know. You will, of course, keep these in strictest confidence. Telling them to others could leave you open to a suit for slander, or libel, or a violation of privacy.

When talking on the office phone, you'll be wise not to mention a patient's name and his condition when anyone might overhear. Legally, such an action could be judged as negligence if it violated the patient's right of privacy or damaged his reputation.

Checking on office hazards: Finally, it will pay you to remember that such things as broken furniture, wet floors, and hot radiators are potentially dangerous. By making routine inspections, you may save a patient from injury and your doctor from a negligence suit. END

the young people we can get to enter nursing?"

"*Whatever* work Doris does, she'll have to adjust to it. A job's a job!"

"Who are *you* to decide which girl will make a good nurse and which girl won't!"

To answer these comments in order:

I *know* young women are idealistic (and many of us older ones are too, I hope!). I *know* we need more nurses. But I can't go along with the statement that a job is just a job—for reasons I'll soon point out.

Quality vs. Quantity

As to why I presume to advise some girls against entering nursing: I firmly believe that, nurse shortage or not, it's more important to get the *right* girls into nursing than it is to get *all* the girls we can round up, helter-skelter.

Good nursing requires as much natural talent as any other profession. And though a bright girl who's unsuited to nursing may learn the work, *she won't be happy and successful doing it.*

Even if *she* doesn't know she has chosen her life's work unwisely, her *patients* will know. They'll know by the back rubs (too brief, too rough); by the mealtime preparations (the cat-lick dabbing, the unbuttered toast and unopened milk, the bed still flat, the tray cooling across the room); and by many other half-done duties that you can name as well as I.

What's She Really Like?

Whenever I talk to would-be nurses, I look for personality traits that clearly show an unselfish, outgoing nature. I look for attitudes and habits that would help make these girls successful at *any* job they attempted.

I choose girls who are willing to play checkers with the elderly man down the street. I choose those who freely help Mother with her household duties and who like to take Brother a tray when he's sick. I choose those who enjoy baby-sitting for the neighbors, with or without pay.

I know I'm not a professional counselor, and I'm glad there are such counselors to help young girls pick their future work. But I'm convinced we R.N.s can help the would-be nurse in a way the professional counselors can't. For *we* know from experience

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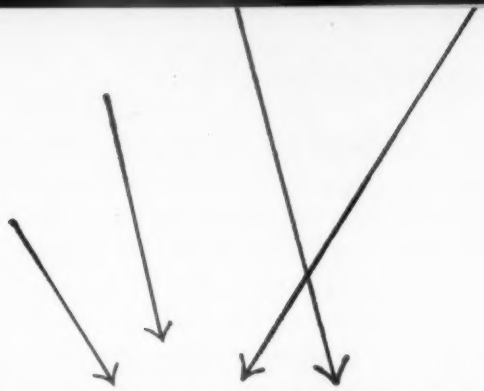


The use of the CORTICOSTEROIDS

BY MORTON J. RODMAN, PH.D.

A new era in medicine began about a dozen years ago when chemists first synthesized the adrenal hormone cortisone. Soon this steroid and its cousin, hydrocortisone, were being used to fight dozens of diseases. And they brought some of the most severe ones to a dramatic halt.

For instance, when given to victims of rheumatoid arthritis, they quickly put out the fire in patients' swollen joints. Many people who formerly would have been permanently crippled were able to resume active lives.

But the first steroids caused disturbing side effects. So the search went on for safer compounds. Now new synthetics, claimed to be safer and more powerful, have come on the scene.

Let's look at some to see (1) how doctors are using them and (2) how safe and potent they really are.

One thing seems certain: The new drugs often do their best work when given for short periods to meet medical emergencies. In many diseases, they spell the difference between comfort and misery. In others, they tide a patient over when his life is threatened.

Consider, for example, the patient suffering a severe asthmatic attack, or one having an allergic reaction to a drug like penicillin:

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J.*

Injecting one of the new soluble steroids such as methylprednisolone sodium succinate (Solu-Medrol) may help pull him through. And for the patient i shock, intravenous steroids ma raise his blood pressure to nor mal after all else has failed.

Adrenocorticosteroid Compounds

Each entry on this list starts with the official or generic name of the drug, followed in parentheses by its trade name(s) or synonym(s).

Adrenal cortex extract, N.N.D. (A.C.E., Eschatin, et al.)
Aldosterone (Electrocortin)
Cortisone acetate, U.S.P. (Cortogen, Cortone)
Desoxycorticosterone acetate, U.S.P. (Cortate, Decortin, Decosterone, Doca Acetate, Percorten)
Dexamethasone, N.N.D. (Decadron, Deronil, Gammacorten)
Dexamethasone-21 phosphate (Decadron Phosphate)
Fludrocortisone acetate, N.N.D. (Alflorone, F-Cortef, Florinef)
Fludrocortisone hemisuccinate (Florinef Ophthalmic)
Fluoromethalone, N.N.D. (Oxylone)
Hydrocortamate HC1, N.N.D. (Magnacort)
Hydrocortisone, U.S.P. (Cortef, Cartril, Hycortole, et al.)
Hydrocortisone acetate, U.S.P. (Cortef Acetate, Cortril Acetate, Hydrocortisone Acetate, Hydrocortone Acetate)
Hydrocortisone cyclopentylpropionate, N.N.D. (Cortef Fluid)
Hydrocortisone sodium succinate, N.N.D. (Solu-Cortef)
Methylprednisolone, N.N.D. (Medrol)
Methylprednisolone acetate, N.N.D. (Depo-Medrol)
Methylprednisolone sodium succinate, N.N.D. (Solu-Medrol)
Prednisolone, N.N.D. (Delta-Cortef, Hydeltra, Prednis, Meticortelone, Meti-Derm, Paracortol)
Prednisolone acetate, N.N.D. (Sterane)
Prednisolone butylacetate, N.N.D. (Hydeltra T.B.A.)
Prednisolone 21-phosphate (Hydeltrasol)
Prednisone, N.N.D. (Deltasone, Deltra, Meticorten)
Triamcinolone, N.N.D. (Aristocort, Kenacort)
Triamcinolone acetonamide, N.N.D. (Kenalog)

Just how the steroids mobilize a patient's defenses is still a mystery. But there's no doubt they *do* buy time in many emergencies. In severe infections, for instance, the steroids support the patient against the stress of infection until the invading bacteria finally begin to go down before antibiotic attack.

The new drugs are even being tried in some diseases where they were once thought to be contraindicated. In tuberculosis, for example, steroids are seldom given for fear they may spread the infection. Yet they've saved the lives of a number of patients with a condition such as tuberculous meningitis.

Antibiotics Needed Here

When given for a condition in which serious inflammation is present, steroids are always combined with the proper anti-infective agents. Here's why:

The steroids somehow break down inflammatory reactions—one of the body's main barriers against the spread of germs. This action often relieves pain and prevents scarring. But, at the same time, it can be dangerous. If inflammation is reduced while a large number of germs are present, the germs may get out of hand. So antibiotics are administered to prevent this from happening.

Because the steroids reduce local pain and swelling, they may be used to treat conditions in which the inflammation itself is dangerous. In eye infections, for instance, steroid-solution drops often suppress sight-threatening inflammation. A soluble steroid such as the new dexamethasone phosphate (Decadron Phosphate) quickly clears up conjunctival redness and removes fluids pressing on delicate ocular tissues. But neomycin is usually given to the patient along with the steroid to stop the spread of infection.

Where antibiotics don't work —as against herpes simplex virus—steroids shouldn't be used at all.

The same goes for skin inflammations. Applied as a cream or an ointment, new steroids such as fluoromethalone (Oxylone) and triamcinolone acetonamide (Kenalog) often bring rapid relief. (They're said to be forty times as potent as the natural hormone hydrocortisone.) But when spreading infection threatens, these drugs are best given in

combination with antibiotic and antifungal agents.

Steroids seem safe enough when smeared on the skin to dry up such infections as weeping poison ivy or contact dermatitis. They're safe, too, in most instances when given in massive emergency doses. They become dangerous mainly when administered over long periods. Yet doctors often find repeated administration necessary for the following reason:

Steroids don't really cure chronic diseases. Often, they just suppress the symptoms. As soon as a patient stops taking a steroid for a condition such as rheumatoid arthritis, it may flare up again, sometimes worse than before. So the physician usually must decide whether the benefits of continued steroid treatment outweigh the disadvantages of its side effects.

Even the latest steroids, though safer in some ways, can cause most of the reactions reported with the earlier compounds. These include the signs of Cushing's syndrome: "moon face," acne-like eruptions, and abnormal growths of hair and deposits

My Most Unforgettable Pa

It was a dreary day outside and I was feeling depressed. I'd just returned to my office in a Los Angeles school after visiting the homes of some of our poorest students.

My office door opened quietly and a thin, pale lad walked in. His blond hair was neatly combed. The much-mended clothing he wore was faded but clean.

"My name's Jimmy, ma'am," he said. "I'm new today. We just moved here from Texas."

I offered him a chair and started filling out his health card. When we came to the address, he hesitated.

"We live in the Chatsworth

of fat. More dangerous reactions include blood pressure rises, psychotic symptoms, and bone fractures from osteoporosis.

However, the newer synthetics seldom cause a piling up of salty fluids in body tissues, called "waterlogging." The lack of this obvious sign of overdosage makes it all the more important to watch for other danger signals.

Steroids tend to mask symptoms of severe illness. And this can be dangerous. For instance: Suppose a patient with a history of peptic ulcer is given steroids for some other condition. And suppose he has a flare-up of his ulcer—or a perforation—at that time. The steroid might mask the warning pain. So doctors often give a patient antacids, or safeguard him in other ways, during steroid treatment.

Patients who need special care when on steroids include:

¶ Diabetics, who sometimes require more insulin because the steroids may increase the sugar content of blood and urine;

¶ Pregnant women, because the drugs may cut down on the adrenal function of the growing

Continued on page 78

Patient

BY DELIA K. CHAFFIN, R.N.

Hills," he said. "But I can't rightly say where. Our home is—sort of unusual. But it's plumb beautiful, ma'am. You should see the walls. They're made of panel wood."

"You mean you don't know your address?" I asked.

"No'm. But I could take you there after school some time."

"Fine," I said. "We'll go today. I'd like to meet your parents."

That afternoon I drove Jimmy back into the hills, following his directions. As we rounded a turn, I saw a fallen plane lying in a grove of pines. I vaguely remembered reading about a plane crash months before. *More*▶

Jimmy pointed proudly. "That's our home," he said.

Unbelievingly, I stopped the car. As we got out, a small, dark young woman opened the plane door and waved to Jimmy. Then a little girl came running to meet us.

Jimmy introduced me shyly. The mother told me that the father was in town looking for work. He'd injured his back some time ago, she said. They'd been trying to find a healthful climate and work that he could handle. Nearly penniless, they'd settled here.

In spite of their misfortune, she was cheerful. She smilingly nodded permission when Jimmy asked to show me their home.

We climbed through the door into the crumpled interior. Jimmy pointed out the smoke-blackened wash basin they used, and the beds they'd made from broken seats. Then he ran his hand over the plywood paneling.

"Isn't it beautiful?" he asked.

The wood was charred and splintered in spots. Most of it had turned a dingy brown. "Yes, Jimmy," I said. "It's beautiful . . ."

When I reached town, I reported the case to the Health Department. Soon Jimmy's father was being treated for his injury, and his family was being moved into a small but adequate house.

Later, I lost contact with the family. But as long as I live, I'll remember that day at the plane. I'll see Jimmy standing beside his strange home, waving happily as I drove down the road. I'll remember something else: that there can be beauty even in poverty when we have the eyes to see it. END

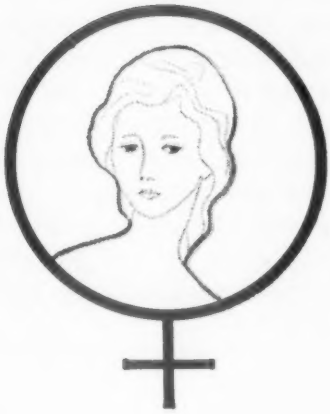
Matter of course

One evening while I was on OB duty, a middle-aged couple came to the receiving room. The wife was expecting her ninth child.

Tenderly, the husband seated her in a chair, put a suitcase beside her, gave her a peck on the cheek, and said:

"Well, good night, Ma. See you in the mornin'."

—RUBY E. ANDERSON, R.N.



Postpartum Mental Illness

By Martha Dudley, R.N.

Recently I visited a former classmate who's now a nurse for a busy pediatrician. When I arrived at her office she was with the doctor, so I waited.

"Sorry to hold you up," she apologized later. "I was telling the doctor about the disturbing symptoms I saw in a new mother."

"I thought you people limited your care to babies only!" I said.

"We do. But we also keep alert for signs of postpartum mental illness in the mother. This mother was just too happy. The office was wonderful, I was wonderful, the baby was wonderful, the day was wonderful! I'm afraid she's due for psychiatric treatment."

I was puzzled. "I remember hearing about postpartum psychosis in nursing school," I said. "But I don't understand why you

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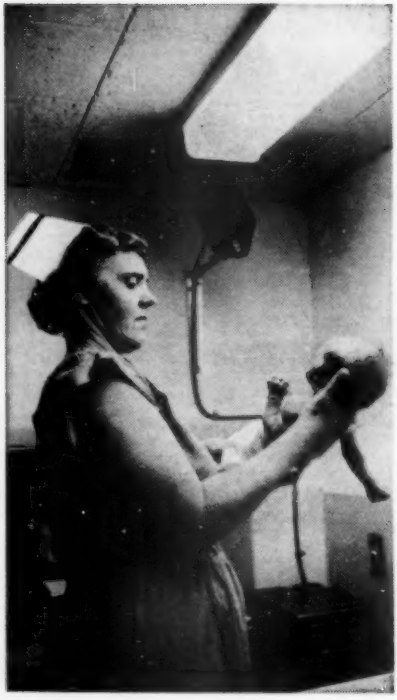
THIS ARTICLE *was prepared with the assistance of Curtis T. Prout,* M.D., *psychiatrist, and Mary Alice White,* PH.D., *psychologist. Both are affiliated with New York Hospital's Westchester Division. A controlled study of postpartum mental illness in which they participated has added substantially to current knowledge of the etiology, symptoms, treatment, and prognosis of childbirth-induced mental illness.*

should be watching for it. Doesn't the psychosis start right after childbirth?"

My friend shook her head. "Postpartum mental illness may start within six weeks of delivery," she answered. "But many afflicted mothers don't show symptoms until well after that time.

"Notice that I said 'mental illness,' not 'psychosis.' Doctors today say there's no such thing as 'postpartum psychosis' per se. They say childbirth may simply act as a precipitating factor, bringing on any one of several incipient mental illnesses.

"Nurses are in a strategic position to spot the danger signals. For they can observe new mothers continuously—among friends



TV Introduces Da

When the intercom in the fa thers' waiting room at th Hialeah (Fla.) Hospital announ ces, "Mr. Jones, please tune i Channel 6," Mr. Jones hops to it

This is the word he's bee waiting for. He knows that a soon as he clicks on Channel 6 he'll be able to see his newly ar rived son or daughter on the TV screen.

Just how does the hospita manage this?

A small video camera, focus ed on an examination table in a room next to the nursery, is con

and neighbors as well as in their work."

During the evening I kept pressing questions on my friend. Soon I'd found out that much new knowledge is now available. I decided that other nurses would be as interested as I was in up-to-the-minute information. So, with my friend's help, I arranged to interview a psychiatrist and a psychologist whose combined work is outstanding in this field.

Here are the questions I asked them and a summary of their answers:

Q. What mental illness is usually associated with childbirth?

A. There's no special syndrome. A woman may develop psychoneurotic, schizophrenic,

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Dads to Babies

nected directly to the TV receiver. Before the nurse calls the father on the intercom, she puts the baby on the table (at left) and switches on the camera. After daddy has had a long look (at right), she switches the camera off again.

The advantages of this system, says Administrator Donald W. Welch, are threefold:

¶ Fathers get to see their babies at once without crowding the nursery windows at times when visitors aren't allowed in the maternity ward.

¶ Children who aren't permitted to visit the ward may view their new brother or sister on TV (a thrill in itself).

¶ In between baby showings, the TV receiver is tuned to other channels to help anxious fathers-to-be while away the time. END

HOW TO SPOT THE NA

More often than most nurses realize, dope addicts and peddlers try to steal drugs from hospitals and doctors' offices. Some break in at night. But many do their stealing in broad daylight, right under the eyes of those in charge of narcotics.

Here's a rogues' gallery of four such culprits. By learning

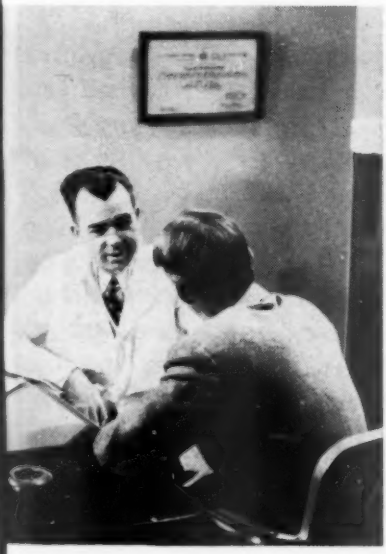
MISS ADDICT, R.N.: *May actually be an R.N. or may be using forged or stolen credentials. Usually chooses a hospital that's desperate for help so they'll hire her before investigating. Often seeks evening or night duty and volunteers for extra assignments that give her access to drugs. When stealing, she substitutes tablets of similar appearance, replaces narcotics in solution with sterile water, forges records, reports missing narcotics as having been "spilled" or "lost."*

SCRUB-BOY JOE: *Self-effacing and apparently industrious. Takes any job he can get that's near a narcotics supply (hospital pharmacies and wards suit him fine). If he's an addict, he may be in a hurry to get his hands on narcotics. If he's a peddler, he waits patiently until he's sure he won't be caught. Here he steals narcotics by using a large flask to hide his action.*

NARCOTICS THIEF

their tactics and then keeping constantly alert, you may be able to help thwart serious thefts of narcotics from the hospital or doctor's office where you work.

These scenes are from the film "Someone Is Watching." It may be purchased after preview from Health Education Service, Box 7283, Albany, N.Y.



"KILL MY PAIN" WHEEDLER: *Persuasive and persistent. Adept at feigning pain. Haunts hospital admitting rooms and doctors' offices. Ticks off a well-rehearsed description of his symptoms. Gives convincing reasons why he needs "a little something to kill the pain."*

MR. REPAIR MAN: *Pleasant and seemingly efficient. May carry tools for his professed trade. Visits doctors' offices, preferably when he knows the doctor is out. Claims he's been sent to service equipment (such as a sterilizer). Relies on your not asking for proper identification and authorization. Here he dupes a doctor's wife into leaving him alone in her husband's office.* END

THE PHONE SURVEY:

A New Aid to Effective

You'll welcome its help in protecting your patients, says this R.N.

The new mother, recently home from the hospital, is surprised and pleased to get a phone call from one of her maternity nurses.

In a friendly, informal way, the R.N. explains that the hospital wants to be sure mother and baby are getting along well. "Your doctor has given us permission to phone," she adds. "We hope you'll help us improve our maternity service by answering a few questions . . . Now I'll start down the list: Was your room kept clean . . . ?"

The mother is glad to discuss her hospital experience. She not only answers the questions but she adds many comments—some favorable, some otherwise.

Staph Control

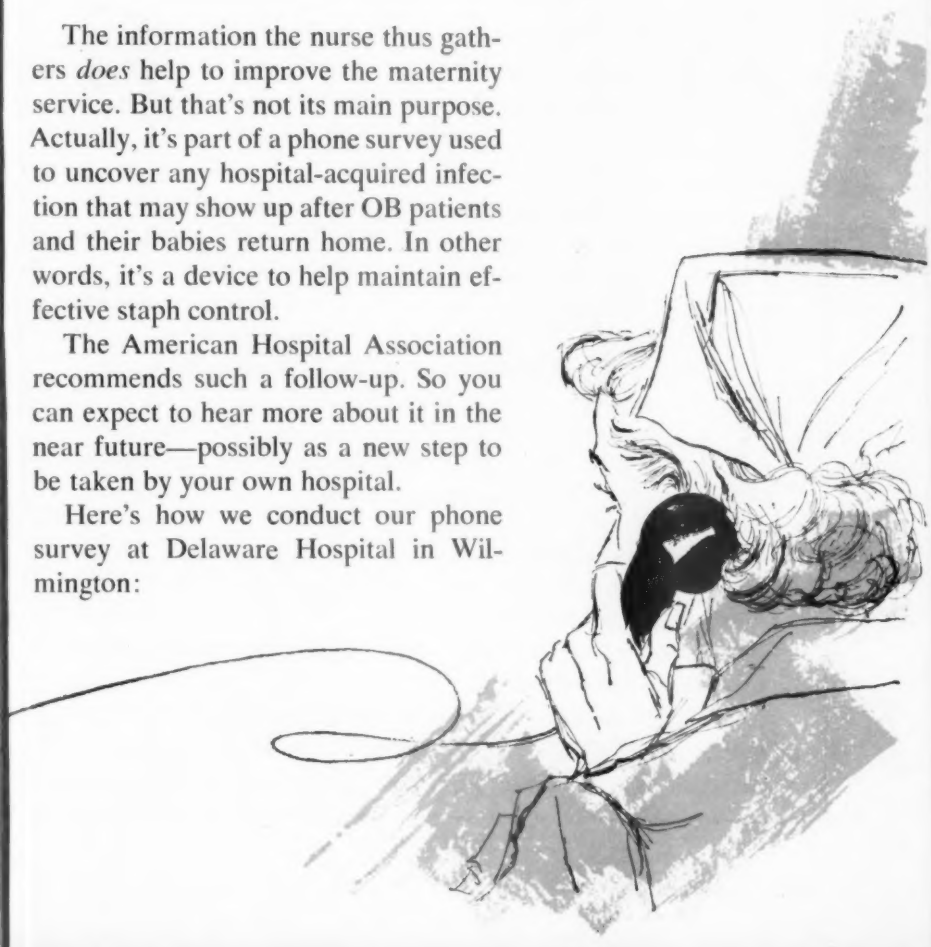
BY DORIS V. DOUDS, R.N.

Here's how the OB department at one hospital tested it

The information the nurse thus gathers *does* help to improve the maternity service. But that's not its main purpose. Actually, it's part of a phone survey used to uncover any hospital-acquired infection that may show up after OB patients and their babies return home. In other words, it's a device to help maintain effective staph control.

The American Hospital Association recommends such a follow-up. So you can expect to hear more about it in the near future—possibly as a new step to be taken by your own hospital.

Here's how we conduct our phone survey at Delaware Hospital in Wilmington:



An R.N. who's a member of the infections committee does the phoning. She uses questions prepared by the committee. She's an OB nurse, so she knows many of the mothers she phones.

She makes her calls several weeks after the patients' discharge to allow for the incubation of any infection. She calls from a list provided by the medical records section. Included are the names, phone numbers, and dates of discharge of patients, plus the sex of each baby. To get a useful sampling, as recommended by the A.H.A., she calls every third patient.

THESE KEY QUESTIONS

. . . are used to elicit the needed information in Delaware Hospital's phone survey of recently discharged maternity patients:

1. Was your hospital room kept clean at all times?

2. Was your food well prepared? Was it hot when served? What was your impression of the girls who served it?

3. Was your baby clean and dry when brought in from the nursery?

4. On your first day at home, did you have enough [hospital-supplied] formula?

5. Has your baby had any diaper rash since coming home? Any infection of the skin or eyes? (Mothers of circumcised male babies are also asked: Has he had any infection following his circumcision?)

6. Have you *had any skin infection since coming home? Have you had any other illness? Have you had any trouble from your perineal sutures?*

7. Have you or the baby needed the doctor for anything other than routine check-ups?

8. Do you care to add further comments about your hospital stay—anything that you feel might be helpful?

The questions she asks are so arranged that she can get the information she wants without upsetting the mother (see the accompanying list). You'll notice, for example, that the specific questions about infection (Numbers 5 and 6) are sandwiched between innocuous ones that encourage the mother to talk freely. Also, each question is stated briefly, allowing the R.N. freedom to ask supplementary questions when she finds they're needed.

For instance, consider Question 5: "Has your baby had any diaper rash?" If the patient answers "Yes," the nurse then asks if the rash has cleared up. If it hasn't, she asks what the mother is doing about it.

The nurse is also prepared to answer the mother's questions. Suppose, for example, the mother asks, "What should I do about the rash?" Knowing that this question puts her on the spot legally and ethically, the nurse simply suggests that the mother consult her physician.

Obviously, the success of our survey—or of any similar one—depends to a large extent on selecting a nurse-interviewer of tact and sound judgment. Ideally, she also has a pleasant, friendly voice and is able to listen patiently and to elicit information without offending. And she thoroughly understands the hospital's staph problem.

Every two weeks the surveying nurse submits a statistical report to the infections committee. With it she includes a two-part résumé of the mothers' comments.

Improving Service

One part pertains to all services, including nursing. These comments help in correcting oversights that cause patient-dissatisfaction. For example:

One mother complained of having felt chilly at night. "There was always a draft in my room," she said.

The remedy: Our night nurses now check room ventilation more often and make sure each patient is adequately covered.

Another mother said: "I was lonely during those first hours in the labor room. Music would have helped a lot."

The remedy: A portable radio is now in use—and patients are delighted with it.

The second part of the résumé pertains to cross-infection haz-

ards. These comments help the committee to tighten its staph-control measures. For example:

One mother complained about dry mopping. "The cleaning woman just pushed the dust around," she said. "My room never seemed really clean."

The remedy: Dry mopping is now banned in patient-care units.

Another mother said she'd

Continued on page 98

NURSING

WHEN GIVING SHOTS TO TINY TOTS

No doubt about it: A baby feels safest when he's in his mother's arms. And that's exactly why I want him there when I'm giving him a shot.

The usual office procedure for I.M.s—laying the baby on an examining table or across his mother's lap—makes him associate a prone position with pain. Result: On subsequent visits, he may start crying if his mother puts him down for any reason.

So, instead of following the usual procedure, I ask the mother to hold the baby close to her shoulder. "Support his head and shoulders with one arm and hand," I tell her. "Put your other arm firmly across the back of his legs."

As she snuggles the baby to her, I quickly pull down the diaper and give the shot in the buttocks.

If the baby cries at all, it's only for a second. Many babies don't even whimper.

The technique has another advantage: The mother, thus kept busy, is spared from watching the injection.

—MAJ. GERTRUDE M. HAYDON, A.N.C.

Getting More Out of Your Bank

These three services many nurses don't know about can save you time and give added financial protection

By Hugh C. Sherwood

You may think of your bank only in terms of the usual checking, savings, and loan facilities. But many banks offer other aids. And a number have added attractive new frills to the three traditional services.

Take savings accounts, for example. You're familiar with the special-purpose account that helps you save money for Christmas or for a vacation. But you may not have heard of these new plans:

1. The "Double Dollar," "Twin Dollar," and "Double Your Money" plans.

Some banks put one of these similar plans in force automatically when you open a savings account; others require you to apply. In either event, you get the following benefit:

The bank buys life insurance coverage on you equal to the amount of your savings. When you deposit or withdraw any money, the insurance goes up or down by a like amount. If you die, your survivors get your sav-

ings *plus* an equal amount from the insurance.

Such an account has certain restrictions, of course. You can't open one if you're over 60 (in some cases, 55). You get ½ to 1 per cent *less* interest (which the bank uses to pay the insurance premium). And you're covered *only* to a limited amount ($2,500 for the "Double Your Money" plan and $1,000 each for the other two).

This means you aren't actually getting "free" insurance. But if you're in your thirties or early forties, you usually save a few dollars a year on what you'd pay for comparable term insurance.

There's a second advantage, too: Banks with such plans don't require a health examination (but they do require you to sign a statement that you're in good health).

The nurse who's otherwise uninsurable but who wants to protect a dependent can get at least some extra coverage through these plans. If she has enough savings available, she can open a "Double Your Money" account in each of several banks, thus adding as much as $2,500 *per bank* to her life insurance program. (She can't do this under the "Twin Dollar Plan.")

Continued on page 80

Be specific, please

The other patient in our semiprivate room was enjoying her visitors. I was in misery.

Finally, I couldn't wait any longer. So I rang my bell.

The little student nurse who'd started her training that morning answered.

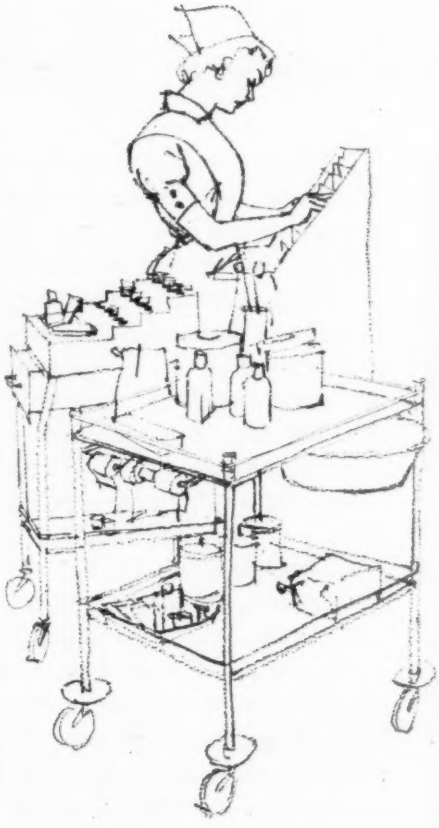
"Honey," I whispered into her ear, "may I please have the pan?"

Obediently, she turned and went out the door—then stuck her head back in. "Pan?" she called out in a loud, puzzled voice. "What kind of pan?" —ELIZABETH L. CARMEN

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

'You Can Have the Surgical Service . . .

I'll Take the Medical Floor!'



In an earlier issue, RN *brought you the opinions of nurses who prefer working with surgical patients. Here's the other side of the coin*

By Hope Patterson, R.N.

"So the medical floor is always gloomy? All the R.N.s there ever do is make beds? . . . What nonsense!" So says a medical-floor nurse—one of many who disagree vehemently with some of the opinions expressed in *RN's* recent article on surgical-floor nursing.*

That article was based on an *RN* study of 200 general-duty nurses throughout the country. The survey showed that about half of those who have a work

*See "Give Me the Surgical Floor Every Time," *RN*, September, 1959.

preference favor the care of surgical patients.

And the other half?

Well, except for a few who say they like to work on a mixed floor, they're as much of one mind as their surgical-floor sisters. "Give us the medical floor every time!" they say in effect.

Their reasons:

They like the challenge of the medical floor.

"Nowhere else," says a California R.N., "can the nurse use

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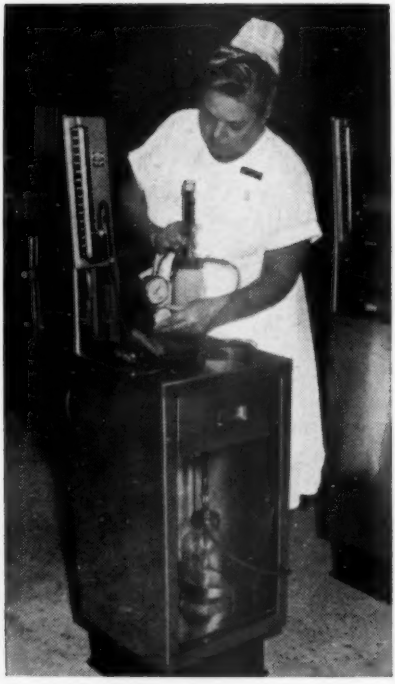
Nurse's Pedestal Saves Ste



The nurse who goes on floor for the first time in the modern twelve-bed recovery room at Baptist Hospital in Pensacola, Fla., gets a surprise. The heads of the beds are lined up along the aisle instead of along the walls. And beside each bed is a shiny stainless-steel pedestal, or cabinet, providing much of the equipment and supplies she needs for post-op care.

Here's the story behind this unique recovery room:

When it was being planned, the administrator asked nurses to submit ideas for improvement. Mrs. Marguerite Chasles, recovery-room supervisor, felt sure *something* could be done to im-

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her skills so effectively. The medical patient's complex symptoms need close observation and careful charting. Often it's the nurse's reporting in such a case that helps the doctor to make a diagnosis and effect a cure. And sometimes it's the nursing care that finally pulls the patient through."

A New Yorker adds: "It's exciting to know that through skill and persistence you can help your patient win his battle with a

Steps in Recovery Room

prove efficiency. So she and the anesthesiologist made a motion study of nursing routine. They found that if the heads of the beds were reversed, an R.N. would save ten steps for each procedure.

Reversing the beds seemed easy enough. Electrical wiring and oxygen and suction tubes could be installed in the floor instead of in the walls.

But a search of equipment catalogues showed that recovery-room devices are made for use with wall outlets only. Using them with floor outlets would cause an impractical clutter.

Undaunted, Mrs. Chasles discussed the problem with several hospital maintenance supervisors. Then she designed a pedestal that solved the problem.

As shown here, each pedestal is equipped with a (1) removable O_2 humidifier and regulator (at Mrs. Chasles' right hand), (2) suction gauge and on/off valve (left hand), and (3) manometer (left corner of the pedestal). A collection bottle is housed under a utility drawer that also holds suction tips and other supplies.

Floor outlets come in under the pedestal. A double electrical outlet is provided at the rear. A positive-pressure unit can be used in place of the humidifier and regulator, as needed. END

long-term illness. Assisting him 'over the hump' takes real fortitude."

They like the opportunities for teaching and for giving emotional support.

Says a Texas nurse: "I enjoy teaching diabetics, for instance —and cardiacs—how to live with their disability."

Adds a Marylander: "Being able to dispel a bedfast patient's gloom and to help him develop a cheerful outlook is incomparably rewarding."

They find the nurse-patient relationship rewarding.

"Our patients depend very much on us and on what we do for them," observes an Illinois nurse. "We get to know them well, too, because they stay longer than surgical patients."

"Long-term patients, especially, appreciate the little things," says a Pennsylvania R.N. And an Arkansas nurse adds: "I wouldn't swap my medical patients for all the in-and-out, three-day surgical patients from Maine to Hawaii!"

They like the chance they get to learn from the many and varied illnesses their medical patients exhibit.

"On a surgical unit, cases are often so nearly alike that learn-

Continued on page 84

Can't blame the Indians

It was my first year in training. I was on duty in the emergency room with the resident physician. A bad accident case was brought in.

The man's face and scalp were covered with clotted blood. So I proceeded to clean him to find the source of bleeding. As I pushed back his hair to wipe his forehead, I suddenly gasped—for his entire scalp lifted up!

The doctor hurried over, took one look, then frowned at me severely.

I got lots of kidding about that unguarded gasp. The accident victim had been wearing a toupee.

—DORA E. METZGER, R.N.

I'm glad I married a nurse, but...

By O. A. Whorton

I love my wife. I admire her in many ways. But between you and me—well, frankly, she talks shop too much. And most of her shop talk is as far over my head as the Explorer satellite.

What in Heaven's name is a bilateral salpingo-oophorectomy, for instance? They did *that* to a woman over on Pine Street and I heard the details over my scrambled eggs for a week. My ears are bent double from listening to such lingo.

It reaches its peak when the Coopers—Joe and Mary—drop by for an evening. Mary is a nurse, too. Result: Joe and I, out in left field conversationally, watch Haystacks Calhoun "rassle" on TV, while our wives ply each other with Sanka and shop talk in the kitchen.

In the course of sixteen years, I have been brainwashed, but good. I now know better than to gripe, say, about a sore arm. Why? Because I'd promptly get a lecture to the effect that "I *knew* you'd strain a muscle sheath when you insisted on tossing that softball until 9 P.M. at the Odd Fellows' picnic!"

And what do I get for a hangover? Sympathy? Empathy? Not on your life! I get a cold stare and "Aspirin, gr. X." Not, mind you, "a couple of aspirin tablets," but the old official jargon.

The shopping list my one-and-only hands me invariably includes some gem such as "Bk.

pulv." I'm supposed to bring home—what? Black pulver?

The manager of the supermarket says he never heard of black pulver. So I ask one of the clerks. A miracle happens and it turns out he's married to a nurse too. "Bk. pulv.," he tells me patronizingly, is baking powder.

But don't get me wrong: My wife merits plenty of praise. I'm proud of her and I tell her so.

Take her stalwart nature, for instance. I like being married to a woman who can face a pool of blood without screaming. (But let's not talk about mice.)

I admire the way she responds to the call of duty—private duty, that is. She doesn't work regularly at the hospital any more; but let an urgent call come for a "special" on a wintry night, and

Continued on page 96

Plea to an M.D. (any M.D.)

The doctor is a worthy gent;
His patients claim he's heaven-sent.
The man is knowing, erudite;
But, holy cats! He just can't write!

The surgeon's hands are deft and skilled;
The surgeon's head is *know-how* filled.
Yet why—since he's so doggone bright—
Cannot the surgeon learn to write?

Dear sons of old Hippocrates,
Pray hear a troubled nurse's pleas:
Remember that the gals in white
Have got to *read* the stuff you write!

Your physicals and histories,
Like Dead Sea Scrolls, are mysteries;
Your order sheets make nurses squint;
So please, dear sirs, write *right*—or print!

—CECILIA HARGROVE, R.N.

I Was Overexposed to Radiation—and Ignored It!

BY BEATRIX ALLEN, R.N.

When I entered University Hospital, I was a likely candidate for the title, Mrs. Mess of the Year.

The ugly abdominal burn I should have shown to a doctor long before was now a deep, festering wound. My blood count was dangerously low. My arms were so swollen that the skin cracked when I tried to bend my elbows.

I was sure my days would end right there; so I painfully scrawled a note to my brother (I'm a widow), asking him to take care of my son after I was gone.

For weeks I lay in despair while the specialists tried to improve my general condition and heal my burn. Then, gradually, my strength increased. But the burn wouldn't heal. So at my request they sent me back to my home-town hospital for treatment—surgery and possible skin grafting.

Our county hospital is a friendly place with the best of doctors and staff. Here much of the fear and tension left me. I even managed a smile when the head surgeon said in his dry way: "I hear you've brought us a prize belly burn."

Yes, I'd brought them a prize burn, all right—and it was the result of mistaken judgment that few present-day R.N.s would be guilty of. I'd handled X-ray

THIS ARTICLE *won an* RN *Award for its author, who writes here under a pen name.*

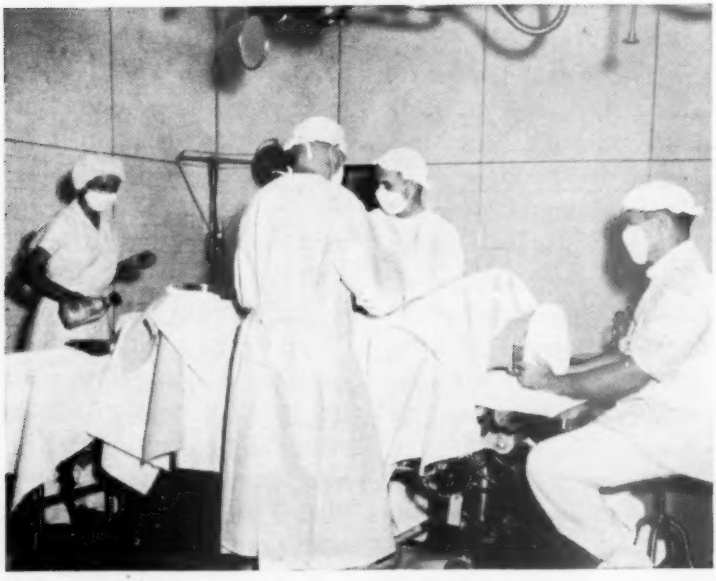
equipment without fully understanding the dangers involved. Then I'd become frightened and had foolishly kept my fear to myself instead of promptly going to a doctor.

Here's how it had happened:

For a number of years I'd operated a portable X-ray machine in a doctor's office. I'd taken instructions in the use and care of the machine. And I understood, in a general way, that exposure

Continued on page 86

O. R. WITHOUT LINENS!



Your eyes tell you otherwise, but you can take the word of the U.S. Army: There are no standard cloth linens in sight here. Everything white you see, including the nurse's uniform, is made of paper. These personnel of the Brooke Army Medical Center at Fort Sam Houston, Tex., are wear-testing disposable paper supplies of all types for possible Army adoption. END

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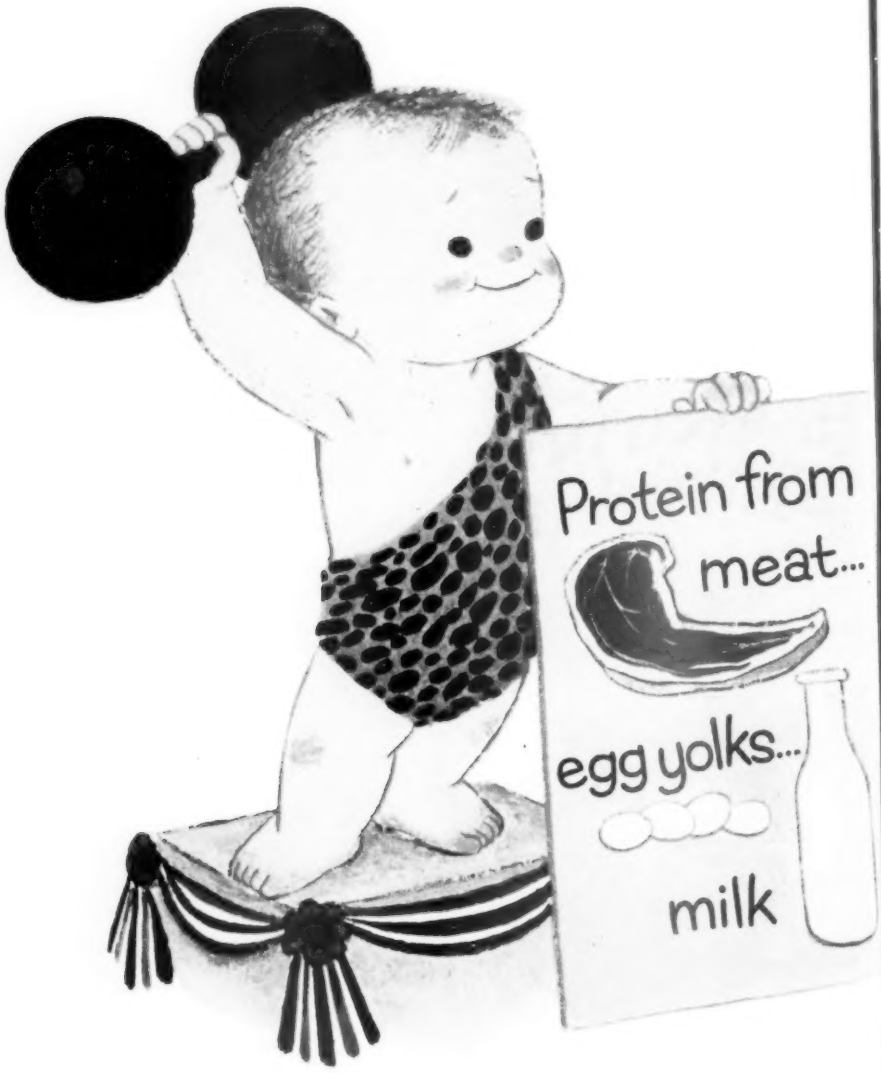

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*Pillsbury, D. M.; Shelley, W. B., and Kligman, A. M.: Dermatology, Phila., Saunders, 1956, p. 813.

AN RN REFRESHER

Giving Eye, Ear, and Nose Drops

By Signe S. Cooper, R.N.

Instilling a drug for local effect requires constant alertness as well as practiced skill. The four suggestions that follow will help you to give drops effectively and with maximum safety:

¶ *Observe the basic precautions for giving any medication.*

Making an error when instilling drops can be just as dangerous for the patient as making an error when administering other drugs. Be *sure* you're giving the right drops to the right patient, and that you're giving the right dose by the right method at the right time.

¶ *Understand the purpose of the drops you're giving.*

For instance, you're confident when you instill a *miotic* in the eyes of the patient with glaucoma, for you know it will cause his pupils to contract, thus relieving intraocular pressure.

But suppose a *mydriatic* is or-

THIS ARTICLE *is the fifth in an* RN *refresher series on drug administration. The author is Associate Professor of Nursing and Chairman of the Department of Nursing, Extension Division, University of Wisconsin, Madison.*

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The nice old lady who scored her pie crusts "TM" and "TM" ('Tis or 'Tain't Mince) never knew which was which. So it is with "homemade" petrolatum gauze...there's always the question of sterility. That's why most hospitals specify 'Vaseline' Sterile Petrolatum Gauze U.S.P. This label insures the absolute sterility that is difficult to attain in hospital-made gauze.

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'TiS STERiLE!

dered by mistake. You know this will cause his pupils to dilate, increasing intraocular pressure. So you immediately check with the doctor to prevent possible irreversible eye damage.

¶ *Gain the patient's confidence and cooperation.*

A tense, frightened patient can injure himself on the dropper by reacting against the procedure at a critical moment. To put the patient at ease, explain in simple terms exactly what you're going to do. Then use firm but gentle manipulation, as needed.

¶ *Follow your hospital's procedure.*

When in doubt about procedural details, check the hospital's procedure book. This applies especially to asepsis, use of equipment, and temperature of the drops.

Generally, medical aseptic technique is adequate. But in some cases (when giving eye drops, for example), sterile technique is required. Also, the hospital may require (1) the use of separate equipment for each patient, (2) the use of a dropper other than the one in the medication bottle, and (3) special sterilization of equipment.

(For a review of the fundamentals of giving drops, consult the chart on pages 72-73.)

New-baby blues

A friend of mine who worked in the out-patient service of a large maternity hospital visited the home of a patient who'd just given birth to her fifth child and first little girl.

As she bathed the infant, the four little brothers gathered around—all happy except the oldest, who seemed ready to cry.

"Gosh," he sighed, "she's beautiful . . . But I bet they'll do what the washing-machine man did: They'll come and take her back before we get her paid for!"

—VIRGINIA L. UGLAND, R.N.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

Fundamentals of Giving Drops

Preparation and Administration

	EYE	EAR	NOSE
EQUIPMENT	Sterile medicine dropper, cotton balls, and medication[1]	Medicine dropper, cotton balls, and medication	Medicine dropper, tissues, and medication
PATIENT'S POSITION	Lying down, or sitting with head tilted back	Lying on side with head resting on unaffected side, or sitting with head tilted toward unaffected side	Lying with head lowered over side of bed, or lying with shoulders elevated above level of head, or sitting with head tilted back
INSTILLATION TECHNIQUE	Identify affected eye; remove any secretion on lids and lashes with cotton ball, then discard ball; expose lower conjunctival sac; tell patient to look up; instill prescribed drops into center of exposed sac; tell patient to close eye; exert slight pressure on inner canthus with clean cotton ball to keep medication from escaping into nasolacrimal duct; tell patient to rotate closed eye to spread medication over conjunctiva and eye's surface; dry lids and lashes with clean cotton ball	Warm the medication; identify affected ear; remove any secretion on external ear with cotton ball, then discard ball; straighten auditory canal;[2] place tip of dropper at canal opening; instill prescribed drops along wall of canal; remove any excess medication with clean cotton ball; keep patient on his side for several minutes to prevent drops from escaping	Have patient blow his nose; if necessary, carefully remove crusts on nares with applicator, then discard applicator; insert dropper 1/2" to 2/3" into one nostril; slowly instill prescribed drops; repeat in other nostril; gently massage sides of nose to insure even spread of medication; have patient keep head tilted back for several minutes to allow medication to spread over the nasopharynx

Precautions

GENERAL FOR EYE, EAR

1. Observe the basic precautions for giving any medi-

Precautions

GENERAL FOR EYE, EAR, AND NOSE

1. Observe the basic precautions for giving any medication
2. Draw into dropper approximate amount of medication needed
3. Hold dropper with rubber bulb uppermost (the solution may become contaminated with particles of rubber if it runs into bulb); don't rest dropper on tray or table
4. If any medication is left in dropper after application, don't return it to stock bottle
5. Use separate dropper for each patient and for different medications
6. Chart medication and patient's reaction

SPECIFIC FOR

EYE

1. To help you correctly identify affected eye, know these abbreviations; O.D., right eye; O.S., left eye; O.U., both eyes
2. Be sure dropper and medication are sterile; use aseptic technique
3. If either eye is infected, use separate dropper to instill drops into uninfected eye
4. Avoid touching lids, lashes, and cornea with dropper
5. Explain to patient any changes (such as altered vision) that will follow instillation of drops

EAR

1. Warm, don't overheat, medication
2. Grasp ear *gently* by pinna
3. Don't force air into canal, for this can cause discomfort

NOSE

1. Draw enough medication into dropper for both nostrils; don't reinsert contaminated dropper into bottle of medication
2. When instilling drops into nares of children or irrational adults, cover tip of dropper with rubber tubing to prevent injury

[1]Eye drops may be packaged in a single-dose plastic container, thus eliminating the need for a dropper and a stock bottle of medication. [2]To straighten an adult's auditory canal, gently pull the pinna *upward* and backward; to straighten an infant's, gently pull the pinna *downward* and backward.

WHAT'S NEW IN *Drugs*

Long-Lasting Eye Drops: A new drug for fighting glaucoma is said to keep ocular pressure down for long periods. Dropped into a patient's eye, this chemical, echothiophate iodine (*Phospholine*), reportedly constricts the pupil promptly and keeps it constricted for as long as four weeks. Thus, it helps open blocked drainage canals and lets excess fluid flow out of the engorged eyeball. The reduced pressure relieves pain and prevents possible blindness.

Echothiophate works by combining with the enzyme cholinesterase, an enemy of the nerve chemical acetylcholine. With its enemy tied up in this way, acetylcholine piles up and thus more messages reach the sluggish eye structures.

Single-Dose Seatworm Cure: Just one dose of a new, bright red dye is said to wipe out all pinworms (seatworms) in a patient. The drug, pyrvinium pamoate, comes as a strawberry-flavored suspension (*Povan Suspension*).

Children who take one teaspoonful for every 22 pounds of weight are reportedly cleared of

the parasite's eggs within a week after treatment. The drug works in adults, too. So it's now being used to keep the parasite from spreading through whole families and entire institutions.

The drug is stated to be harmless. It isn't absorbed, but passes through the intestinal tract. Because it stains the stool a blood red, patients are warned in advance.

Relief for Stuffy Noses: A new nasal decongestant, xylometazoline (*Otrivin*), is said to give long-lasting relief. It's also described as being relatively free of the usual side effects of nose sprays and drops, such as nervous stimulation and "rebound congestion."

Xylometazoline reportedly keeps capillaries constricted, shrinks swollen membranes, and promotes drainage from blocked sinuses. This helps allergy sufferers to breathe freely again.

German Drug for Itch-Control: A new antihistamine, clemizole (*Allercur*), controls itching and has few side effects, say German allergists who've tried it.

Taken by mouth, clemizole tablets quickly relieve pruritus, it's claimed, whether caused by allergy or other conditions. The tablets are said to stop hay fever symptoms, too, without making patients drowsy, as some antihistamines do.

—MORTON J. RODMAN, PH.D

When to Advise A Girl Against Nursing

Continued from page 38

the attitudes that make a good nurse and a *happy* one.

Let's use this knowledge to encourage and recruit those who have what it takes. At the same time, let's not hesitate to dissuade those who are obviously unfit.

Nursing is too fine a profession to sacrifice quality to mere numbers. I, for one, will continue to do everything I can to save it from becoming a haven for the second-rate. END

Do you have convictions either for or against the view this author expresses? If so, you're invited to submit them in a letter. RN *will publish a cross-section of such opinion.*—ED.

Nurses are happier when doctors choose Fleet® Enema

They appreciate its freedom from the troublesome, time-consuming preparation and cleanup procedures of old-style enema methods. With the ready-to-use Fleet Enema squeeze bottle, nurses can give an enema in less than a minute, with the least discomfort or embarrassment to the patient. Insertion is made easy and safe because of the pre-lubricated, anatomically correct 2-in. rectal tube.[1]

Fleet Enema provides a quick yet thorough cleansing action with only 4½ fl. oz. of precisely formulated, standardized solution.[2] Widely useful for a variety of diagnostic and therapeutic purposes—even for patients on sodium-restricted regimens.[3] Systemic absorption is negligible.

100 cc. contains: 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate in 4½-fl.oz. squeeze bottle. *Pediatric Size,* 2¼ fl.oz. *Also available:* Fleet Oil Retention Enema, 4¼-fl.oz. ready-to-use unit containing Mineral Oil U.S.P.

1. Frech, H. C., and Lanier, L. R., Jr.: Am. J. Obst. & Gynec. 74:1146, 1957. 2. Rosenfield, H. H., et al.: Obst. & Gynec. 11:222, 1958. 3. Hellman, L. D.: To be published.

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The Use of Corticosteroids

Continued from page 43

fetus, thus making the newborn baby defenseless against disease-stress;

¶ Emotionally unstable people, who can break down under high steroid dosage. (Psychotic tendencies are usually a contra-indication for steroid treatment.)

Anyone on long-term treatment may suffer depression of adrenal function. So the drugs are never stopped abruptly lest the patient have trouble meeting emergency situations that call for hormone support. To stimulate the patient's sluggish adrenals to resume their activity, some doctors give corticotropin (ACTH) injections at intervals during or after long-term therapy.

As long as a year or more after steroid treatment, a patient may have trouble coping with stressful situations. If he undergoes surgery, for example, the lack of corticosteroids of his own may bring on collapse. So the physician on the case may give him adrenal steroids to combat this hazard.

Even though extreme care is often needed in administering the steroids, doctors can't withhold them from certain patients. These may include people with chronic arthritis, pemphigus, chronic bronchial asthma, lupus erythematosis, ulcerative colitis, and a host of other hard-to-handle, long-term illnesses. Such patients are always given *the least possible dose to produce and maintain the desired benefits.*

Combating Side Effects

The steroids' side effects may be minimized by giving a compound locally. Such use on the skin and in the eyes has already been discussed. A steroid may also be injected directly into a sore joint. This localizes anti-inflammatory action and keeps the person from suffering undesirable metabolic effects. In ulcerative colitis, retention enemas containing a steroid may help heal lesions.

To sum up: The steroids are among our most powerful weapons against disease. Even the latest synthetic types have their dangers. But the benefits of steroids, when used with skill and care, usually outweigh their drawbacks. END

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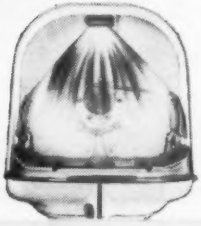
Automatic, positive decontaminat with the American Cyclo-flush protects patients and hospital personne by limiting the carrying of communicable diseases via bedpans and urinals. The electromatic Cyclo-flush thoroughly washes all inside and outside surfaces of pan and chamber with a 25-second cycle of air-entrained cold water — then instantly, steam at 212° F. saturate interior of chamber for 30 seconds . . . killing communicable disease organisms. End result is a sparkling clean utensil ready for use in *any* department or ward.

o Cyclo-flush is finished in s enamel, assuring protec- against residual stain and Flushing of chamber and s complete and thorough.



Time-saving feature of the Amsco Cyclo-flush is important additional benefit. Upon insertion of pan into Cyclo-flush chamber, nurse is free to leave unit and do other work . . . while the utensil is being cleaned AUTOMATICALLY.

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Getting More Out Of Your Bank

Continued from page 56

2. The "Packaged Savings Plan."

Under this agreement the bank handles the time-consuming details of diversifying your savings. You agree to make weekly or monthly deposits over a period of time you select.

The bank puts part of your deposits into your savings account, part into U.S. Savings Bonds, and part into any kind of life insurance you designate. (If you include insurance, you usually have to take a health examination to qualify.)

Suppose you agreed to deposit $5 a week for ten years. Under one typical plan, you'd accumulate $1,490 in savings, $500 in savings bonds, and $5,000 in life insurance, plus interest and dividends. After the ten-year period, you could keep the insurance in force by continuing to pay the premiums yourself.

3. The "All-Purpose" credit card.

If you find that your wallet is now bulging with assorted credit cards and your mailbox bulges with end-of-the-month bills, you may want to look into this service. Here's how it works:

Upon application from a nurse who has an account, the bank issues the credit card. This enables her to charge all purchases made at member firms in her area. (For instance, holders of a Chase Manhattan credit card can charge purchases at more than 5,000 stores in and around New York City.) At the end of each month, the card holder gets a single bill from the bank covering all purchases.

The usual charge for this service? Nothing. The bank gets its profit from small percentages paid by the member business concerns.

But there's one thing to watch for. You'll add to the bank's profit if you don't pay promptly at the end of the month. For interest rates on your unpaid balance are generally a steep 1 to 1½ per cent a month (about 12 to 18 per cent a year).

These are some of the major new banking services of interest

to the nurse. Your banker can tell you of others that will help you in special situations (for instance, when planning a trust fund). Like the above services, they may help you save time while getting the most for your hard-earned dollars. END

Nurse-Administered Test Helps Save PKU Babies

BY VIVIAN L. LEGGE, R.N.

Chances are you'll be hearing more about the important new wet-diaper test that nurses are giving at a number of baby clinics. Here's why it's being used and how it's done:

About one in every 20,000 newborn babies today lacks a body enzyme needed to metabolize phenylalanine (an amino acid found in protein foods). The condition brought on by this lack is called phenylketonuria, or PKU. When a baby has this ailment, phenylalanine piles up in his body and in his excreta. The excess brings about irreversible brain damage, stopping mental growth.

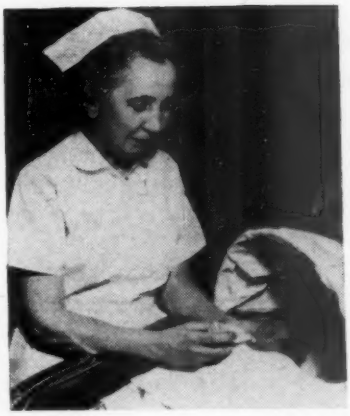
Fortunately, putting the baby on a low-phenylalanine diet can prevent or reduce the progressive damage. But PKU must be diagnosed early and treatment started.

The diaper test spots the condition in some babies as early as two weeks after birth. But monthly testing for a year is often advised. Here's the procedure:

The nurse places a drop of 10-per-cent ferric-chloride solution on the wet diaper. If the baby's urine is normal, a yellow spot appears. If phenylpyruvic acid is present, a green spot appears, indicating PKU. (If the baby has taken aspirin, the spot is purple, so the test is repeated.)

An inexpensive reagent strip may be used instead of the solution. The strip also reacts by changing color. END

She Saves Preemies



You've probably heard of the famous nursery at the Michael Reese Hospital in Chicago. Now meet the R.N. who heads it. She's Evelyn Lundeen, often called "the nurse who never gives up."

Back in 1925 Miss Lundeen helped organize the Michael Reese premature center and started her long career as its supervisor. By its second year, the center had reduced its mortality rate about 20 per cent.

Now, 12,000 babies later, Miss Lundeen's work is so well known that Illinois honors her as a Nurse of the Year. Government health officials come to her for advice. State and national organizations ask her to conduct institutes and training courses. Nursing schools use the three books she has co-authored.

What's the secret of her success in this difficult field?

First, when Evelyn Lundeen looks at a premature baby, she looks into the future and sees the healthy, happy adult that this tiny one could become.

But that's only the start. She and her co-workers are so intensely interested in the welfare of these tiny babies—and, as a team, have done so much pioneer work in preemie care—that the entire staff is constantly on the alert for new tools and new techniques. Staff nurses never relax their care for a moment, day or night.

Today many hundred former preemies whose chances for life were very poor when they entered the Michael Reese center are leading normal, useful lives. This is the reward for vigilance that Evelyn Lundeen and her co-workers treasure most. END

'I'll Take the Medical Floor!'

Continued from page 60

ing opportunities level off," says a Wisconsin R.N. "But medical conditions are always interestingly varied. For example:

"A patient may have several ailments at once. Two patients with the same ailment may require different treatment. A medical illness may be acute or chronic, severe or mild, rare or common. The chance to learn is unlimited."

Says a New Jersey nurse: "Watching the day-to-day progress of a patient with a rare disease builds up as much suspense in me as reading a mystery story . . . I never cease to marvel at the miracles of healing I see here almost daily."

They enjoy the varied routine.

Because patients' illnesses are varied, the routine is also varied, say many nurses. One midwesterner points out that when she's on surgery, she tires of the day-in, day-out sameness of prepping and giving pre-op hypos. Others say that post-op care, too, becomes largely routine after the first postoperative day.

They like the cooperation they get from doctors.

A charge nurse sums up the R.N.-M.D. relationship thus: "Medical men often take the nurse aside, explain the patient's condition, and clarify the nursing needs. In contrast, surgeons tend to be abrupt—to spend little time on the ward after surgery."

As a parting shot at their surgical-floor colleagues, a number of medical-floor nurses make statements like these:

"We admit that your work has some advantages: For instance, recovery-room care and early ambulation help to ease your load . . . We're glad for you.

"As for us, we get our satisfaction from working with the medically ill. We find it a rich, rewarding experience. That's why so many of us say, 'Give us the medical floor every time!' " END

laughable

If this word describes an experience you've had in the course of your work as a nurse, why not share the story? For each anecdote accepted, *RN* pays $15 to $25. Address: Anecdotes Editor, *RN*, Oradell, N.J.

I Was Overexposed To Radiation— And Ignored It!

Continued from page 64

to X-rays could be dangerous. But the machine was easy to operate, and I felt I knew enough about it to protect myself. So I went confidently ahead, day after day.

The machine was an old model with no screen or other protection for the operator. Whenever it was needed, I warmed it up. Then I helped hold a large cassette while the patient had his chest X-rayed.

Exhaustion First Symptom

After a few years, I began to feel continually exhausted. At first I blamed my fatigue on overwork. Then the fear grew that I'd been overexposed to radiation.

Looking back now, I find it hard to understand why I didn't tell the doctor how I felt. But I didn't.

Finally, when I had become so exhausted that I simply could not handle the heavy office work any longer, I changed to private duty.

I'd hoped the rest between cases would help. But each day, whether at home or on a case, I found that it was still a constant battle to keep myself going at all.

I ached so much all over that I started taking a heating pad to bed with me. Then one morning I discovered the pad had burned my abdomen just enough to make it red.

The burn didn't hurt much at first, and it didn't blister or break the skin. So again I put off going to a doctor.

A Foolish Delay

As time passed, though, the burn grew steadily worse. Unbelievable as it sounds, I suffered for six months before I finally gave up and went to see my family physician.

Now here I was at last in my home-town hospital, awaiting surgery.

I don't remember a thing about the operation. Our anesthetist is a man of superior ability, and he did his work well.

My two surgeons tell me they had to make an incision from hip to hip. Then they had to scrape away both layers of skin and the

DIAPER RASH

responds

to quick action

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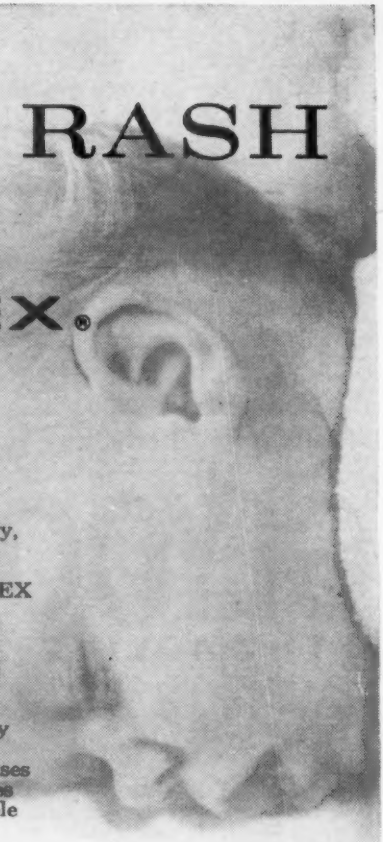

Diaper Rash—always irritating—*can* be a source of infection. Medically tested HOLLANDEX SILICONE OINTMENT fights infection, while it soothes, deodorizes, protects, and helps stimulate skin repair. Medicated HOLLANDEX goes on smoothly, pleasantly, forming a water-repellent, oil-free film. Containing Hexachlorophene, a proven, mild, non-irritating antiseptic, HOLLANDEX acts against and protects from bacterial invasion. Because it's rich in cod liver oil and vitamins A and D, HOLLANDEX safeguards affected areas while maintaining the healing process.

Adults use HOLLANDEX too. Its specially processed base of lanolin provides highly efficient skin protection and treatment in cases of chafing, prickly heat, sunburn, insect bites and common minor skin irritations. Available at all retail pharmacies in 1 oz., 2¾ oz. tubes and one pound jars.

Contains: Silicones (dimethylpolysiloxane), Norwegian Cod-Liver Oil, Zinc Oxide Hexachlorophene, Improved Lanolin.

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Manufacturers of Koromex Products

fascia to find tissues the X-rays and the burn infection hadn't harmed.

They are skillful men; and by doing some intricate suturing, they were able to pull me together, thus avoiding skin grafting that could have meant repeated operations and many months in bed.

During three weeks in the hospital and five months at home, I received the latest medications to help heal my incision and overcome the effects of my long exposure to radiation. Gradually I put on weight and regained my strength.

Today I feel better than I have for years. But I can't help but wonder: Has my life span been shortened? Will other serious after-effects show up?

It's impossible to tell, my doctor says. But I get regular checkups. And if any suspicious symptoms should come along between times, I'll go to him at once. It's comforting to know that he knows what to look for and can help me fast.

Why am I telling my story now? Not only to warn about radiation dangers. But also to spotlight how real and ever-present such dangers are.

One of my teachers once ask-

ed a nursing class: "What's worse than being ignorant?" I can answer her now: As far as the nurse is concerned, these two things are much worse than being ignorant:

Having too much confidence in knowledge that doesn't go far enough.

Believing that your daily duties and family responsibilities are so important that you can't take time off to look after your health. END

▶ **AMUSING . . .**

▶ **AMAZING . . .**

▶ **EMBARRASSING . . .**

▶ **INTERESTING . . .**

No doubt one of these adjectives describes some incident that has occurred in the course of your work as a nurse.

Why not share the story with other R.N.s?

If it's accepted for publication, you'll receive $15-$25.

Contributions must be previously unpublished. They cannot be either acknowledged or returned. Those not accepted within ninety days may be considered rejected.

Address: Anecdote Editor, *RN*, Oradell, N.J.

Postpartum Mental Illness

Continued from page 47

or manic-depressive symptoms.

Postpartum mental illness is very much like what is sometimes called a college neurosis or a war neurosis. When a boy goes to college or joins the Army, this of itself doesn't make him mentally ill. But the stresses of his new life may be too much for him. In the same way, having a baby in itself does not cause a mother's illness. She just happens to have the baby at a time when she can't handle the complexities of motherhood on top of an already difficult life situation.

Q. Are there specific factors that seem to predispose women to postpartum mental illness?

A. Yes. In the order of frequency as shown in our studies they are:

1. An unstable marriage.
2. A long-standing personal maladjustment (about 30 per cent of mothers who develop postpartum mental illness have had previous mental difficulty).
3. Immaturity.
4. An erratic family history.
5. An unusual financial, or

What makes Ivory Soap so pure...something that goes into it, or something that's left out?

Both! Because with Ivory, purity has a double meaning. Only the purest possible, the most carefully refined raw materials go into Ivory. On the other hand, there is nothing in Ivory that doesn't contribute to pleasant, efficient, and truly gentle cleansing performance. The result is a soap that's pure . . . mild enough for a baby's skin. More doctors recommend Ivory Soap than any other for baby and adult patients.

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other, responsibility imposed by the baby's birth.

6. An unwelcome baby.

7. An illness of mother or baby (especially extreme fatigue of the mother).

8. A difficult home situation.

9. A recent traumatic experience (such as a death).

Often a combination of these triggers the illness, which isn't confined to the birth of the first baby. About half the mentally ill mothers we've seen reacted to a later child.

Q. How soon before or after delivery does the illness occur?

A. Very few women we've studied showed any symptoms before childbirth. Mothers who developed schizophrenia tended to do so soon after delivery. About half the psychoneurotic and manic-depressive disorders occurred within six weeks. But at least 30 per cent of all patients who developed mental illness showed no symptoms until well after six weeks.

Surprisingly enough, difficult pregnancies and deliveries don't seem to increase the incidence of mental trouble. However, unsuccessful tries at natural childbirth—in which the mothers finally had to accept anesthesia—may precipitate attacks.

Q. How widespread is this illness?

A. We believe it affects between one delivering mother in 300 to one in 750, or 6,000 to 15,000 women yearly. The larger figure is the more probable.

Q. What are the common symptoms?

A. They usually appear as exaggerated reactions to the normal birth events. Any undue tension or display of restlessness, or unusual ideas or extremes of mood may be taken as danger signals.

You can expect a normal mother to be upset about some small defect in her baby, or to have an occasional attack of "new-baby blues." But the mother with incipient mental illness may show undue anxiety about everything. She may insist there's something wrong with an obviously normal child. She may be whiny, or show extreme hostility toward her husband.

Sometimes she'll talk about a hideous dream she had during anesthesia. Again, she may be frighteningly quiet. Or she may be overly happy.

Q. What is the approved treatment?

A. Hospitalization and psychotherapy are basic. And some-

times electroshock therapy helps.

Hospitalization removes the patient from the situation that's overwhelming her. She's no longer burdened with the care of the baby. Instead, she herself gets good nursing care.

Gradually she begins to understand how her illness came about. As she improves, she may ask for her baby's picture. She starts welcoming her husband, and she talks about the baby. Then she goes home for an occasional week-end. Eventually she's able to resume the mother role.

Q. What is the outlook for recovery?

A. It's relatively optimistic—but *only* if the patient stays in the hospital until her doctor discharges her. Hospitalization may last from three months to a year. Those who leave too soon jeopardize their chance of making a full recovery.

Our statistics show that three out of four patients make a reasonably good recovery. Three out of five recover fully. (Manic-depressives and psychoneurotics do somewhat better than schizophrenics.) Many discharged pa-

tients later bear other children and suffer no recurrence of symptoms.

Q. How can the nurse help the new mother who seems to show symptoms of mental illness?

A. She can report these symptoms to the doctor at once. And she can give the patient immediate emotional support. This is especially important in the case of the woman who feels she has failed at natural childbirth because she had to accept anesthesia.

On the OB ward, the nurse can be alert to thwart possible suicidal or homicidal attempts.

Also, she can back up the doctor when he advises hospitalization. She can emphasize, both to the patient and to her family, the importance of the patient's remaining in the hospital for as long as the doctor prescribes.

Finally, she can share with her patients, friends, and neighbors her knowledge of the excellent prospects for full recovery from postpartum mental illness. By so doing she'll bring increased courage and needed consolation to many. END

I'm Glad I Married a Nurse, But . . .

Continued from page 62

she's out the door while I'm still trying to set the electric blanket dial at 9 to replace her warmth.

The kids—all four—are proud of her too. "We're the luckiest ducks," says 6-year-old Tommy. "We got a nurse for a mom."

Charlie agrees with him completely. He remembers the time he had his tonsils out. There wasn't a sign of fear or trepidation as the two of them waved the rest of us good-by in the hospital lobby—he with his suitcase, Mom in her cap.

On the other hand, I'll admit to you privately that I like the way Mom can baby *me* without destroying my ego. I realize she probably learned the technique while on the pediatric floor. But it still helps when I'm blue.

Of course, I don't get away with much. There's no use trying to play sick on a blue Monday. The little woman is at her diag-

nostic keenest at 7 A.M. A cool palm on my forehead, a firm pressure at the wrist, and I'm as good as on my way.

She saves money on doctor bills by calling the doctor only when he's *really* needed. She doesn't make a career of calling doctors as some mothers do. (One of my friends who *isn't* married to a nurse says he's thinking of hiring an M.D. to live in.)

Another thing: I like my wife's good common sense. Being a nurse has made her a sound thinker. At least she doesn't emote the minute a domestic crisis arises. She doesn't cry or scratch or bite when she's losing. And she doesn't rub it in when she wins. A smart cookie, Mom.

Her ability to support herself is never a sore spot with us. Her salary may have looked pretty good in the old days; but we have four kids now, so I bring home most of the bacon. My wife agrees that it takes two to tango and two, also, to raise a family.

All in all, I'm glad I married a nurse. But I still say: She talks shop too much. END

'MY MOST UNFORGETTABLE PATIENT'

Chances are that you've had one patient who stands out in your memory apart from all the others.

If so, why not share the experience with other R.N.s?

If your contribution is accepted for publication, you'll receive $15-25 for it.

Experiences must be original, true, and previously unpublished. They cannot be acknowledged or returned.

Address: Unforgettable Patient Editor, *RN*, Oradell, N.J.

The Phone Survey: A New Aid to Staph Control

Continued from page 54

been very uncomfortable when lying on soiled bedding. "Doesn't this increase the danger of infection?" she asked. "Shouldn't the sheets be changed every day?"

The remedy: Disposable paper pads are now used. And they're changed as often as a change is needed.

* * *

Such a phone survey can help to improve both staph-control measures and patient-care. Fortunately, in more than 300 calls made on behalf of Delaware Hospital not a single case of hospital-acquired infection has been uncovered. This seems to show that for the present, at least, our OB section has staph pretty well under control. So now we plan to extend our survey to another department.

As an R.N. who has seen this technique in action, I highly recommend it to nurses at other hospitals where cross-infection may be a problem. END

letters

Continued from page 14

competence. Experience should count, too—especially when considering those who are too forty-ish to start a college education.

M. Bankhead Haskell, R.N.
Corvallis, Ore.

SCAR-TISSUE PROBLEM

DEAR EDITOR: Dr. Curtis P. Artz' articles on the care of burns were helpful to me in two recent cases. But they didn't answer one question: If a patient has severe burns, can anything be done to prevent thick scar tissue from forming?

Ruth Zercher, R.N.
Upland, Calif.

Theoretically, prevention of infection and prompt grafting will reduce the possibility of thick scar-tissue formation, says Dr. Artz. But practically, in severe cases, infection often can't be prevented and grafting must be delayed. Also, keloid formation may cause thick scars.—ED.

NURSE AT HEART

DEAR EDITOR: I gave up nursing in 1939 to enter the field of X-ray technology. But I didn't leave the nursing profession. I still belong to the A.N.A.

At heart I'm still a nurse, and proud of both my professions. I continue my membership in the A.N.A. because I appreciate its constant efforts to raise our stand-

letters

ards and because I want to help continue this work for the benefit of future nurses.

Ethel Sullivan, R.N., R.T.
Sioux Falls, S.D.

VANISHING SERVICES

DEAR EDITOR: Many of the little services that used to be a traditional part of nursing are now delegated to ancillary workers. As a result, the nurse who wants to give total patient-care gets little satisfaction from her work.

Can't we devise some way to recognize and honor the R.N. who is truly devoted to giving comfort to the patient?

It does seem that nursing instructors could at least make students realize that bedside nursing *can* be an important and satisfying work.

Doris E. Parkhurst, R.N.
Binghamton, N.Y.

O.R. TRAINING

DEAR EDITOR: . . . Here's one reason why R.N.s are vanishing from the O.R.: Nurses without recent O.R. experience who are hired for the O.R. often must take a refresher before their pay starts. Technicians are paid while being trained.

Helen T. Scott, R.N.
Chicago, Ill.

DEAR EDITOR: Many recent nurse-graduates shun O.R. work simply because their hospitals fail to offer them proper training in O.R. technique.

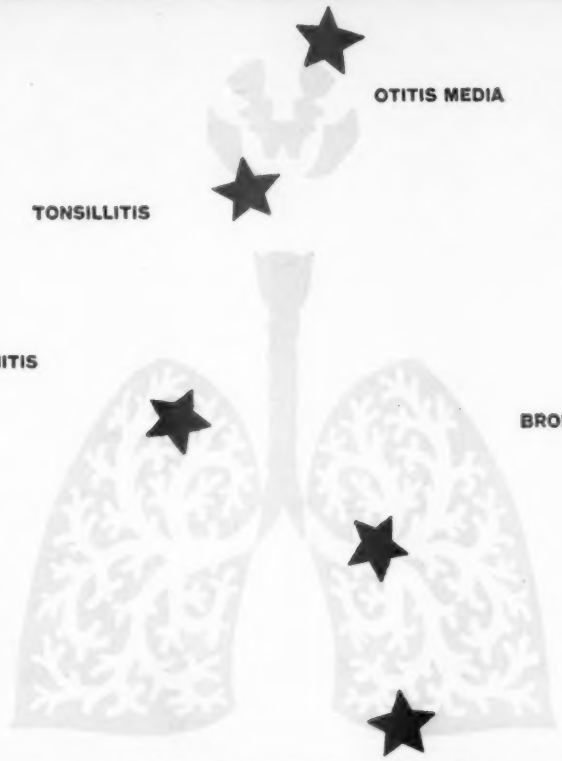
Mary C. Lowe, R.N.
Assonet, Mass.

UNIONIZATION IN L.A.

DEAR EDITOR: During World War II we had a union of registered nurses in the Los Angeles area, organized into (1) an industrial section and (2) a hospital section.

A few members in each group worked hard to make the union a success. But most merely paid their dues. They seldom attended meetings, and they criticized the actions taken by those who did attend.

Because industry is covered by



EWER TREATMENT FAILURES IN RESPIRATORY TRACT INFECTIONS

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ALTAFUR®

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effective perorally against the majority of common infections caused by pathogenic bacteria including the antibiotic-resistant staphylococci

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1. Lysaught, J. N., and Cleaver, W.: Proceedings of the Detroit Symposium on Antibacterial Therapy (Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959).

THE NITROFURANS . . . a *unique* class of antimicrobials

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collective bargaining laws, we were able to get many benefits for the industrial group. But we couldn't do much for the hospital group.

When the war ended, membership dropped in both sections. Finally, we lost our union charter.

This experience proves once again that any organization is strong *only* if its members are willing to attend meetings and to back its leadership.

Nurses can get better working conditions and better pay—but only if, instead of feuding among themselves, everyone pitches in and helps strengthen the present state and national nursing organizations.

Clarence Romeyn, R.N.
North Hollywood, Calif.

'OUR FABULOUS A.N.A.'

DEAR EDITOR: Social Security went into effect for many people in 1939. But nurses had to wait fourteen years to be included under its benefits.

When the laboring man got the eight-hour day and the five-day week, did nurses get them? No. Again they had to wait many years.

Yet our fabulous A.N.A.—"the Voice of Nursing"—talks about its great contributions to our profession!

Meanwhile, why are we so poorly paid? (I make $8.35 a day—thanks to our A.N.A.)

Plainly, we need another organization to represent us.

Florence Lookretis, R.N.
Bridgewater, Va.

'IT ISN'T SO!'

DEAR EDITOR: I've heard it said, even by R.N.s, that only hard-hearted nurses accept work with the mentally retarded and the physically handicapped.

It isn't so! I've been working with such patients for two years. They greatly need T.L.C.—and we gladly give it. The longer we work with them, the more interesting the work becomes.

Elizabeth C. Smith, R.N.
Austin, Tex.

ODE À LA MODE

DEAR EDITOR: Stop, look, and glisten!

A dermatologist claims that salad oils and shortenings have a beneficial effect when used as skin lotions. Wow! I can't hold back the following:

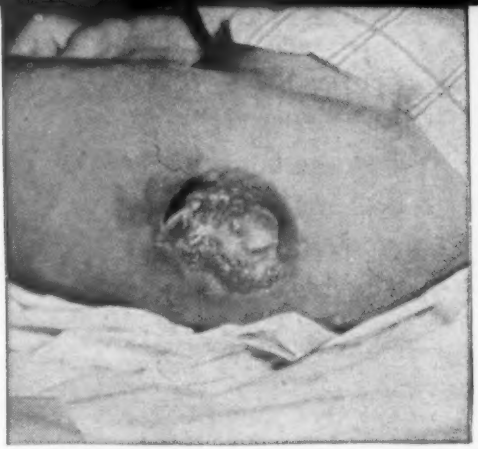
When the glamour goil
  Uses Wesson Oil,
I'll become Miss San Francisco
With Mazola (yi!)
  Or a can of Spry
Or some Fluffo (my!)—or Crisco!

R.N., California

CREDIT-UNION DUES

DEAR EDITOR: Am I right in assuming that hospital credit unions must

Helps Heal Pressure Sores Quickly



Before the application of White's Vitamin A & D Ointment—*Severe pressure sore in area over greater tuberosity of femur.*

WHITE'S VITAMIN A&D OINTMENT

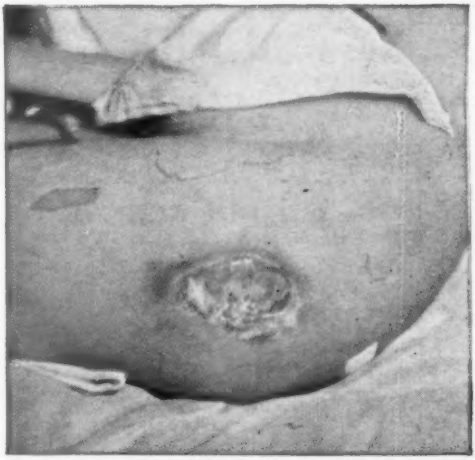
HEALS / SOOTHES / PROTECTS

irritated skin

also beneficial for

– DIAPER RASH, NIPPLE CARE (fissured nipple), EPISIOTOMY and CIRCUMCISION WOUNDS, VARICOSE and CHRONIC ULCERS; ECZEMA, DETERGENT DERMATITIS; MINOR BURNS and WOUNDS and SKIN ABRASIONS.

Supplied in 1½ and 4 oz. tubes; 1 lb. "nursery" jars and 5 lb. "ward" containers.



After daily treatment with White's Vitamin A & D Ointment — *The sore is now filled with granulation tissue and shows signs of re-epithelization at margins.*

White

WHITE LABORATORIES, INC. KENILWORTH, N.J.

letters

help to support their national and state organizations? I find no mention of association dues in your recent article on credit unions.

Jacqueline Willingham, R.N.
Hackensack, N. J.

You're right. The Credit Union National Association is supported by an annual levy on each credit union of 8 cents a member. A credit union that belongs to a state league must also pay a percentage of its yearly income to the league. (In New Jersey, for example, the league gets 3 per cent, but not more than $600 a year, from each credit union.)—ED.

SAVE THE 3-YEAR COURSE!

DEAR EDITOR: I'm unalterably opposed to closing the hospital schools and putting all nursing education on the collegiate level.

That level has its advantages, I realize. But for my money I'd rather see the standards raised in the many hospital schools that now lack accreditation.

R.N., New York

NEW DAY

DEAR EDITOR: I've been in nursing twenty-five years and I wouldn't want the "old days" back on a bet —even if that were possible.

In those days there were no L.P.N.s or aides to help carry the load. And bedside care meant back-breaking treatments that kept

the nurse on her feet throughout her twelve-hour shift.

Today, we're on the threshold of a new era, with stress on leadership and teamwork. Yet many nurses feel frustrated because they're not able to give the patient more personal attention.

Why?

Sometimes I think it's because they don't realize that patients have changed, too.

Today's typical patient wants a "quickie" cure—in and out of the hospital in the least possible time. He views the R.N. as a specialist, trained to administer what the doctor orders in the way of new treatments and drugs.

True, patients still enjoy a friendly chat. But they no longer expect the "head nurse" (as they often call the R.N.) to do the menial tasks.

R.N., Michigan

STEP-SAVING IDEA

DEAR EDITOR: The nurse shortage might be eased, I think, if hospitals did something about the unnecessary walking that nurses now do.

They might, for example, install dumb-waiters—one, say, to carry sterile goods from central supply to the various nursing floors; another on which to return the unsterile items.

Frances J. Kelly, R.N.
Neptune, N.J.

END

news

Continued from page 26

The caller who arrives between visiting hours can write an appropriate greeting and hand the card to the receptionist. An average of 250 visitors a month do this at Arkansas Baptist instead of waiting to see the patient.

capsules

Breast cancer is more likely to occur in the left than in the right breast, the American Cancer Society reports . . .

A new spray called Vapor-Phase is said to keep **O.R. instruments rust-free** when applied to the outer muslin wrapper of each instrument before autoclaving . . .

Donors who faint shouldn't give blood again, warns a Florida M.D. If a donor's heart happens to be diseased, he says, donation may cause myocardial infarction . . .

Only R.N.s with special OB training can be licensed as **midwives** under New York City's new health code . . .

Isolation for thrush doesn't reduce the incidence of this infection among nursery babies, say Brooklyn researchers. Reason given: There are always foci of infection in the nursery because thrush fungus may be present in the newborn for five or six days before it shows itself . . .

Radioactive iodine, given orally, slows the hearts of patients with **auricular fibrillation**, says Dr. Eliot Corday of Los Angeles. It produces this effect, he believes, by slowing the metabolism . . .

Diabetes test papers shouldn't be used to determine fertility-cycle conditions, warns the Food and Drug Administration. Some com-

the Operating room nurse—It's almost 3 AM by the clock on the wall . . .
She is near exhaustion from the tension of a surgical race with time . . .
The patient, safe and secure in his recovery bed,
does not know it yet, but he will be well again . . .
She gave him her utmost in knowledge and skill . . .
As well as her night of sleep . . .

A tribute to the nursing profession by the makers of Modess® Tampons . . . the flexible tampon

panies have marketed devices for applying the papers to the cervix, it says, and at least one of the papers contains tolidine, which may injure vagina-cervix tissues.

Reported adaptations of the jet-flier's **pressurized "G-suit":** (1) to keep the patient's pulse rate and blood pressure constant when he's undergoing neurosurgery in a sitting position; (2) modified into an inflated, corset-like garment to give relief from low-back pain . . .

In at least one state—Illinois—a private duty nurse can get help from the state labor department in **collecting unpaid fees** up to $200...

The addition of a corticosteroid, prednisolone, to whole blood pre-

What's Going On Here— An I.V.?

Looks like an infusion, but it isn't. It's a simple, time-saving way to keep an infant's head dressing continuously moist . . . A metal coat hanger, secured to the crib with adhesive, holds an I.V. bottle containing the prescribed solution. A stopcock on the tubing regulates the drip-rate. "That's all there is to it," say pediatric nurses at St. Joseph Hospital in Lancaster, Pa., where the handy unit was devised and is shown in use. END

A double-blind range-of-motion study[1] has reaffirmed the exceptional analgesic action and safety of BEN-GAY® in rheumatoid arthritis, osteoarthritis, bursitis, and allied disorders—and its usefulness in muscle and joint pain due to exertion and exposure.

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1. Brusch, C.A., et al.: Maryland M.J. 5:36, 1956.

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vented **transfusion reactions** in 58 patients with a previous history of such after-effects, says a report to the American Society of Anesthesiologists . . .

Culture vs. love: Twelve British nurses recently formed a **"no-dates" club** so they'd have time to enjoy the cultural advantages of Oxford University. The first casualty? Their president. A college man changed her mind after two dates in a row . . .

Theory advanced by a U.S.-Canadian team to explain **infertility:** Blood-group antigens in the cell walls of spermatozoa are blocked or immobilized by antibodies in cervical secretions . . .

Persons with **rare blood** are being urged to join a newly formed National Rare Blood Club. Members will give blood to each other when needed . . .

A new device, the Wecktronic tester, reportedly indicates any **rubber-glove puncture** when the glove-wearer places his hands in a saline solution . . .

The development of new drugs, not the extension of surgery and

radiation, provides the best hope for **curing malignancies,** says an adviser to the National Cancer Institute . . .

New Jersey school boards can enforce **compulsory vaccination** against diphtheria even when parents object on religious grounds, a state superior court ruled recently . . .

New on the market: A transfusion set that's said to eliminate the fear of **air emboli** in giving blood . . .

Prompt administration of **penicillin after injury** may be more effective than tetanus antitoxin, contends Dr. Edward S. Stafford of Johns Hopkins University. Tests show that when given within two hours, antibiotics prevent the growth of tetanus organisms, he says . . .

Bothered by **sore eyelids?** Frequent shampooing may correct the condition—which seems to be caused by dandruff, says the Pennsylvania Medical Journal . . .

Two developments in **plastic surgery:** (1) use of minute skin and nerve grafts from a patient's uninjured fingers to restore the sense

news

of touch to damaged fingers; (2) use of secondary layers of skin and fat from a patient's body for breast reconstitution . . .

New surgical technique: A Honolulu doctor reportedly removes **ruptured cervical disks** by making an incision in the front of the neck, thus avoiding the spinal cord . . .

Columbia University researchers report discovery of a bacterium that produces elastase, an enzyme with promising possibilities for the **treatment of atherosclerosis.** Until now, elastase hasn't been available for large-scale tests . . .

M.D.s at Portsmouth (Va.) Naval Hospital report success in early diagnosis of **multiple gestation** via EEG tracings . . .

To fight the nurse shortage in Milwaukee, the Board of Public Welfare recently promised to **refund full tuition** to senior students at the county's nursing school who agree to work a year in county institutions . . .

Occlusions of the carotid artery often cause **strokes,** contends a Memphis M.D. He says angiograms showed 108 such cases among 629 victims of stroke . . .

Medical societies should see to it that more M.D.s are appointed to

advisory committees for **nursing education,** says the A.M.A. House of Delegates . . .

If you're taking the tranquilizer **chlorpromazine,** don't drink, warns a Madison (Ind.) State Hospital research team. Chlorpromazine intensifies the physiological effects of alcohol, the team has discovered . . .

The National Broadcasting Company is organizing an FM system to beam **medical news** and reception room music to M.D.s five days a week . . .

Peptic ulcer occurs three to four times more often among rheumatoid arthritics than among patients generally, a Mayo Clinic study indicates . . .

ECG studies reported to the Central Society of Clinical Research suggest that some tracings formerly thought to indicate **heart disease** may now mean a healthy heart . . .

Colorado **school nurses** may soon have to meet certification requirements of the state education department. A pending proposal, supported by organized nursing, would require at least 15 college credits in education, social work, school nursing, and public health work. END

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Many women don't know that a vinegar douche is as old-fashioned as the copper tub, a relic of an empiric age.[1] Acids actually make mucus discharge more tenacious. On the other hand, soaps and harsh alkali are irritating. A detergent douche – TRICHOTINE, the only major douche containing sodium lauryl sulfate–is the modern, more efficient yet gentler vaginal irrigant.

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1. Goodman, L.S. and Gilman, A.: The Pharmacologic of Therapeutics, MacMillan, 1955.

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ESTHESIA COURSE: The Memorial Hos- l, Danville, Va., offers an 18 mos. course Anesthesia for registered nurses. All nts and techniques taught. Complete main- nce and stipend paid for entire course. roved by The American Assoc. of Nurse sthetists and G.I. Approval; participant he Exchange Student Program. Classes pted in May and November. For informa- write Miss Virginia L. DeMaio, C.R.N.A., ctor, School of Anesthesia, The Memorial pital, Danville, Va.

ESTHETISTS: (a) Complete responsibility service, 25 bed hsp. Texas ranch, minimum 0; (b) Fee for service basis, adjoining . Mich. summer-winter resort area; (c) act as Asst. Adm. small hsp. Hawaii; (d) nly for 250 bed hsp. Lake Michigan, $6600 ; (e) Join staff large hsp. commuting nce, NYC, $6000 plus. RN 3-2 Burneice on, The Medical Bureau, 900 N. Michi- Ave., Chicago 11, Ill.

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T. DIRECTOR NURSES: 267 bed JCAH roved hospital. Near Philadelphia. Charge In-Service education for graduate staff. or M.A. Degree preferred. Salary com- surate with experience and education. ctor of Nursing, Chester Hospital, Chest- Pa.

TENTION GENERAL DUTY NURSES: bed County Hospital located 2 hrs. drive n San Francisco, ocean beaches, and ntain resorts in modern and progressive of 35,000. 40 hr., 5 day wk., 3 wks. pd. ation, 11 pd. holidays, pd. sk. lv., retire- t plan and social security. Accommoda- in Nurses' Home, meals at reasonable s, uniforms laundered without charge. $341 mo. start plus shift and service differentials. Must be eligible for Calif. Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, Calif.

ATTRACTIVE OPPORTUNITY: A new 50 bed wing, now under construction, allows us to offer attractive positions, all shifts and types. Starting salaries $305 day, $330 eve., $320 night, $320 surgery. 215 bed JCAH Hospital (when construction is completed) Capitol City, growing medical center. Home of Frontier Days, Metropolitan Denver and resort areas 2 hrs. away. Excellent personnel policies, 40 hr. wk., 2-3 wk. vacation, sk. lv., new Nurses Residence at reasonable rates. Apply Dir. of Nursing, Memorial Hospital, Cheyenne, Wyo.

CALIFORNIA: Registered Nurses general duty with opportunity for advancement. New, modern 130 bed general hospital in dynamic college city in beautiful San Joaquin Valley only 2 hrs. from Los Angeles. Only eveni g and night positions open. Beginning salary $350 per mo. 5 day, 40 hr. work wk. Progressive personnel policies. Transportation cost to California will be reimbursed after 2 yrs. satisfactory service. Send full particulars immediately to Director of Nursing Service, Greater Bakersfield Memorial Hospital, P.O. Box 26, Bakersfield, Calif.

CAMP NURSE: June 15-August 30. Room, board, bedding, modern cottage furnished. Salary $550. Uniform only Sunday registration. No classes to teach. Camp located southwestern Mich. on Lake Michigan, operated by Congregational Churches of Illinois. Write E. Schroeder, 2614 Willa Drive, St. Joseph, Mich.

CENTRAL CALIF.: Staff R.N.s basic salary $325, 40 hr wk. Write Nurse Supt., enclose picture. Hanford Community Hospital, Hanford, Calif.

CLINICAL INSTRUCTOR FOR OPERATING ROOM: In hospital diploma program with NLN accredited school of nursing. Student body 200. Experience and preparation desirable. Salary commensurate with experience and educational preparation. Apply to Director of Nursing, The Toledo Hospital, Toledo, 6. O.

CLINICAL INSTRUCTORS: In Medical Nursing and Obstetrical Nursing. Large general hospital located in fine residential district. School of Nursing full accredited by the N.L.N. with a student body of 199. Educational preparation and experience preferred. Salary dependent upon qualifications. Position open January 1, 1960. Apply Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

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credited hospital. College town of 30,000, 85% sunshine belt, modern personnel policies. Beginning salary $500 mo. Write Administrator, Memorial General Hospital, Las Cruces, New Mex.

DIRECTOR OF NURSING, OBSTETRICAL SUPRV, OPERATING ROOM SUPRV, CLINICAL SUPRV: New Lutheran 100 bed hosp. near Los Angeles, open about May 15, salaries open. Apply Administrator, Pacoima Memorial Luth. Hosp., P.O. Box 95, Pacoima, Calif.

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FREE TRANSPORTATION FOR REGISTERED NURSES: Spend your Winter in the Sunny Southwest, in New Mexico, "The Land of Enchantment." Vacancies for staff duty on Med.-Surg., O.B., Pediatrics and O.R. Free transportation via 1st Class Air to Albuquerque and return in exchange for 1 yr. employment contract. Apartments available at $43 per mo. Excellent job benefits, no shift rotation. Salaries $300/mo. to start, $15 differential evenings and nights. Write or call Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue S.E., Albuquerque, N. Mex. Phone CHapel 3-5611.

GENERAL DUTY NURSES: Needed for period June 1 thru Sept. 30. Also one each OBS and Operating Room nurse. Why not plan to spend your summer in Bar Harbor gateway to Acadia National Park. Enjoy the cool sea breezes away from the summer heat. Write for details. Mt. Desert Island Hospital, Bar Harbor, Me.

GENERAL DUTY NURSES: Salary $300 mo., increments every 6 mos. for 3 yrs. to $360 mo. Bonus 3-11 & 11-7 40 hr wk. Attractive nurses' home. Opportunity for advancement. Apply K. M. Sweeney, Director of Nurses, Princeton Hospital, Princeton, N.J.

GENERAL DUTY NURSES: 60 bed hospital in the Recreational area of Central Oregon. $335 for 40 hr. wk. in O.B. and M.S. depts. on 3-11 shift. Progressive personnel policies. Write Director of Nurses, Central Oregon District Hospital, Redmond, Oregon

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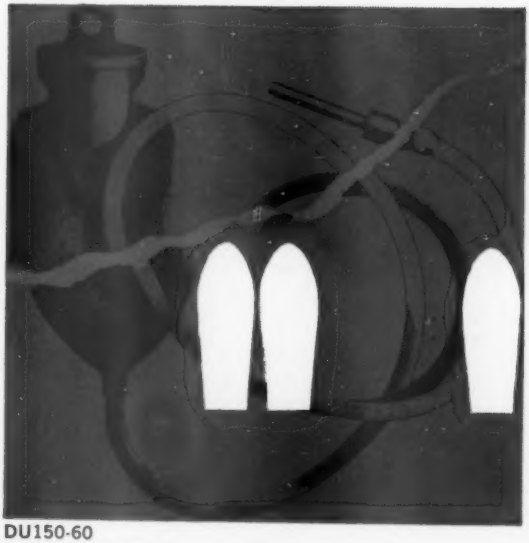

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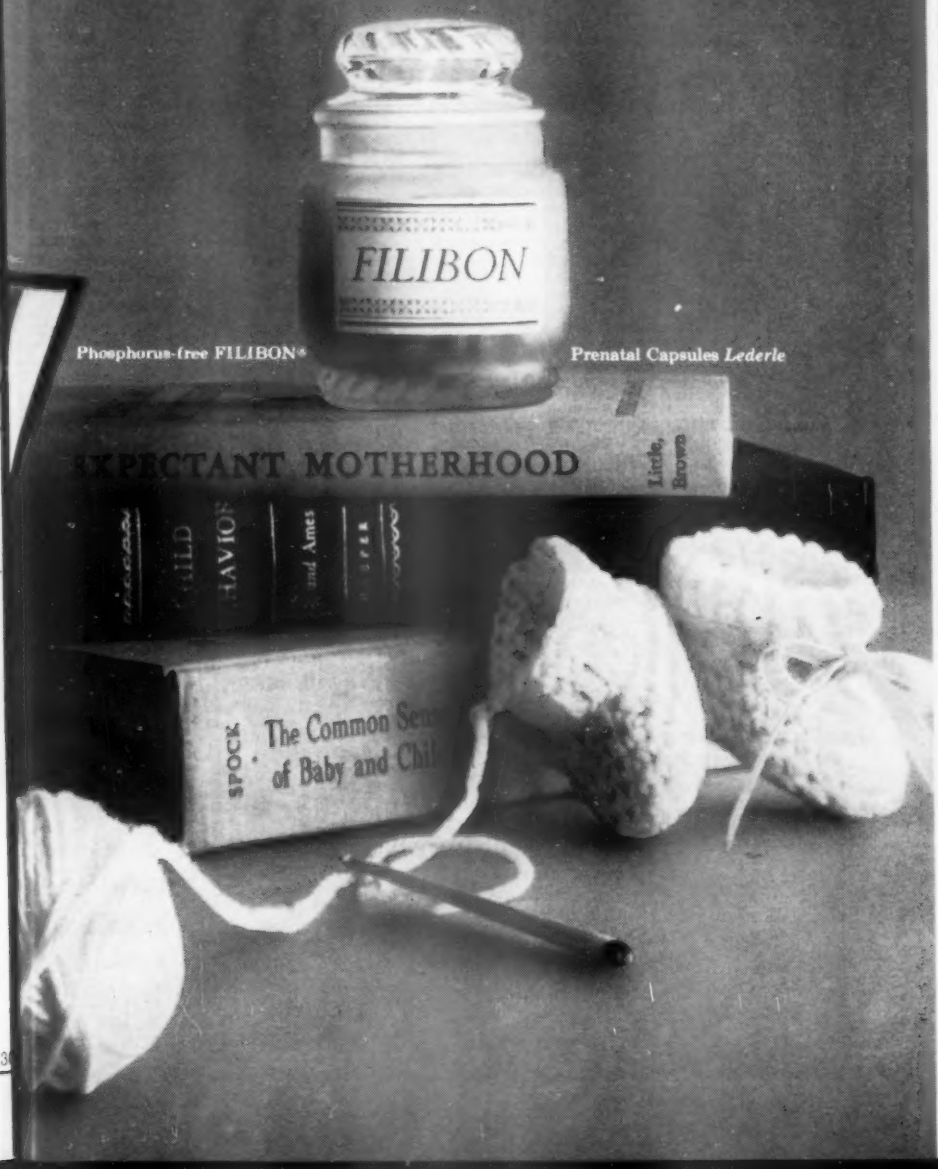

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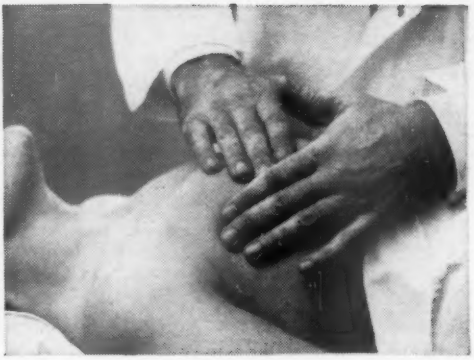
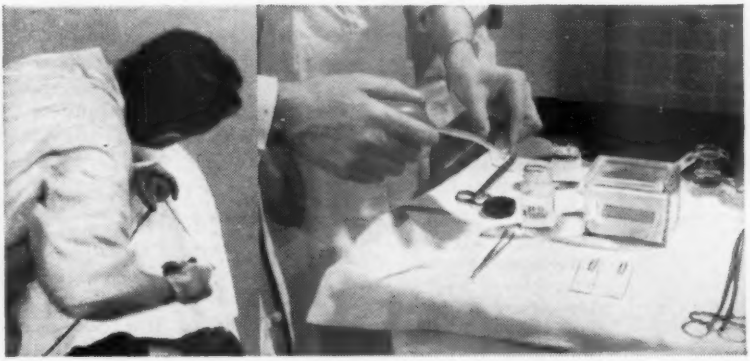


Cancers of the breast, cervix, and rectum . . . three common and too frequently fatal sites of cancer . . . can often be controlled through early detection and proper treatment. The methods and means are available **now.** Yet many more cures in these sites could be effected than are now being achieved.



The American Cancer Society, in its broad public education program, emphasizes the importance of an annual health examination for all adults. It also brings to physicians information on the value of regular examination of the breasts, the routine "Pap" smear, and the proctoscopic examination, to save lives from cancer.

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You see only the top of a pimple. The real trouble is inside because a pimple is basically a clogged, inflamed pore. That's why Skin Specialists agree that for truly effective topical treatment of pimples, patients need the *Clearasil action* . . . which brings the medications down inside the pimple where antiseptic and drying actions are needed. Skin Specialists say that this is the reason why CLEARASIL medication works so fast, so effectively to clear pimples.

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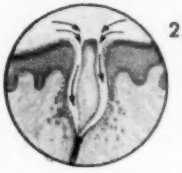
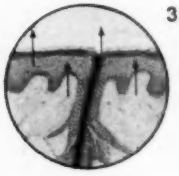


2. ***Stops Bacteria.*** Antiseptic medication penetrates to any lower infection, stops growth of bacteria. Encourages quick growth of healthy, smooth skin.



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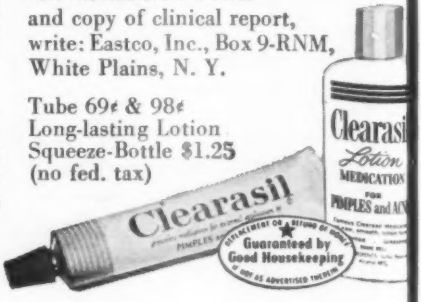

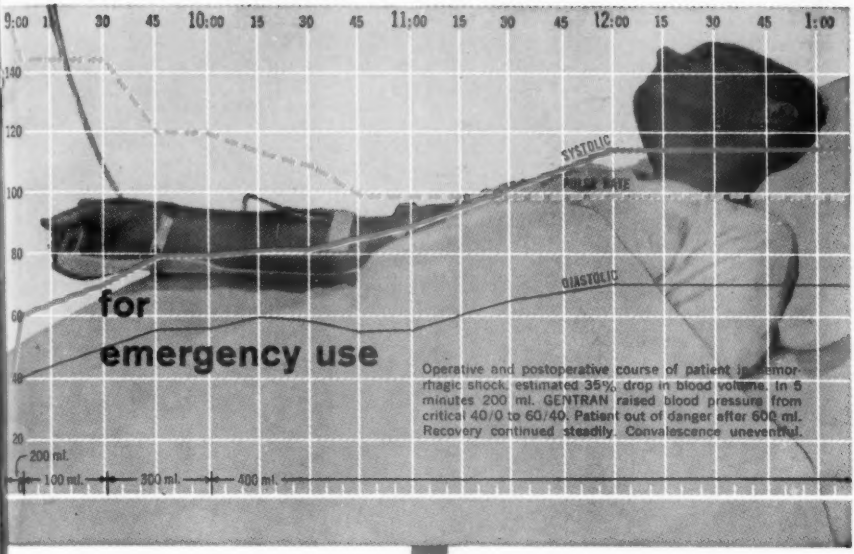

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BUFFERIN contains an exclusive combination of antacids, DI-ALMINATE*, to reduce this hazard while imparting analgesic and anti-inflammatory benefits.

BUFFERIN has been described as ". . . the drug of choice where prolonged high salicylate levels are indicated."[1]

1. Tebrock, H. E.: Ind. Med. & Surg. *20*:480-482, 1951

*Bristol-Myers trademark for aluminum glycinate and magnesium carbonate.

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